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WESTMINSTER INQUESTS

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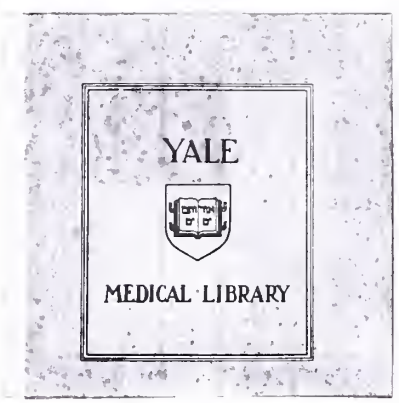
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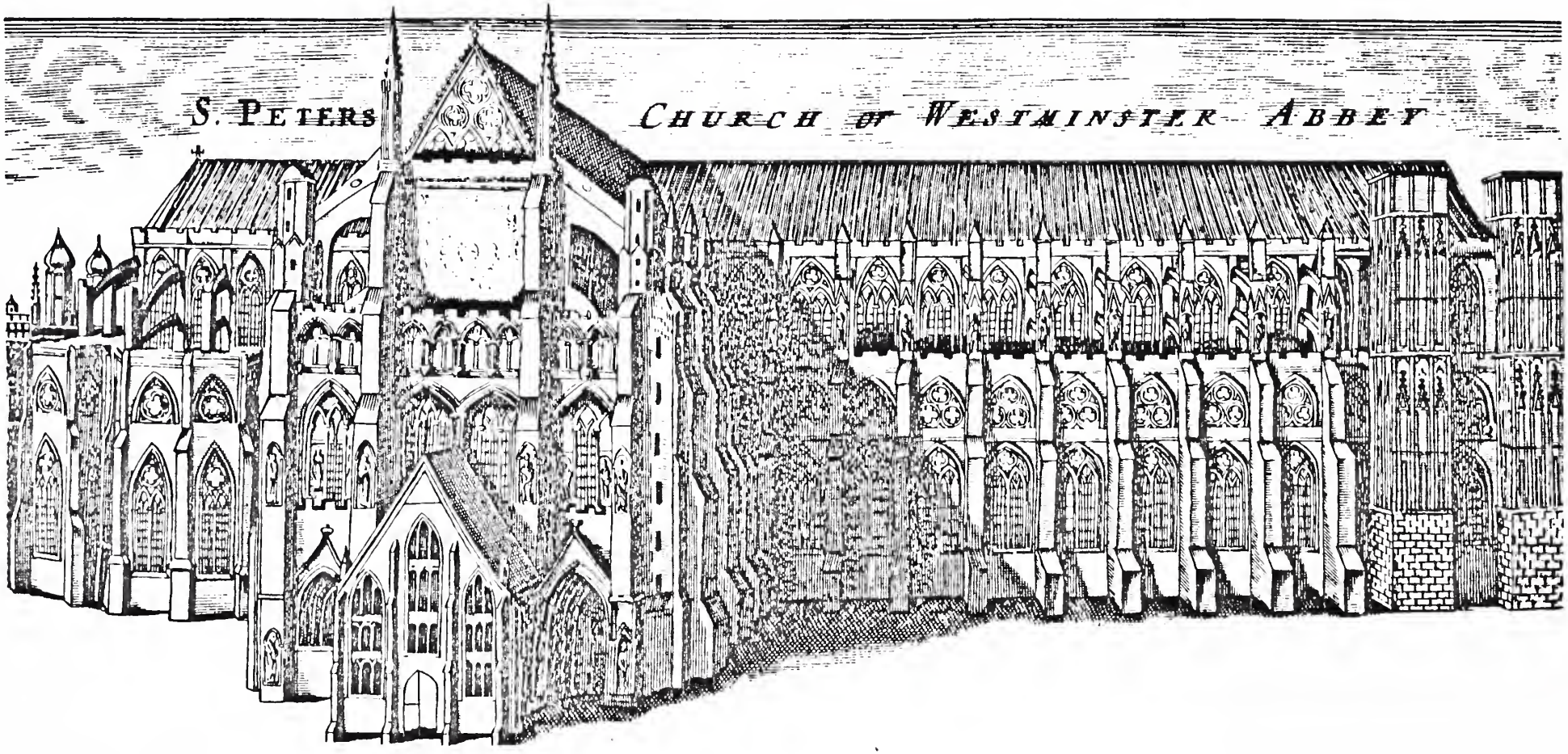
S. Peters Church of Westminster Abbey

WESTMINSTER INQUESTS

Maria L. White

A Thesis

Submitted to the

Yale University School of Medicine

In Partial Fulfillment of the Requirements

for the Degree of

Doctor of Medicine

Dedicated to

Dr. Thomas R. Forbes

Emeritus Professor of the

Yale University School of Medicine

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THE ORIGINS OF THE ENGLISH CORONER

The origin of the coroner is both obscure and controversial. There have been claims that the coroner existed in Anglo-Saxon times. One stems from a treatise of questionable integrity, written by a town clerk in 1688, which alleged without documentation that the coroner was involved in a case during King Alfred's reign (871-910).[1] The coroner is also mentioned in a charter to the monastery of Beverley dated 925 but further investigation has shown the charter to have been forged and it dates from a later time.[2] The Mirror of Justices is yet another document ascribing the office of coroner to King Alfred's reign. The Mirror is attributed to Andrew Horn, a fishmonger who was also Chamberlain in London from 1319-1328, and is filled with a mixture of both valuable and misleading information.[3] The first undisputed reference to the coroner is in September 1194 when in the Articles of Eyre is declared that "Furthermore three knights and one cleric shall be elected by each county keepers of the pleas of the Crown."[4] The earliest treatises known to describe the functions and duties of the coroner were written nearly a century later by Bracton[5] and by Britton,[6] but it is well established that the coroner was active, and even at the height of his powers, before these works in the thirteenth century.

It is most probable that the office of coroner was a Norman invention introduced sometime in the beginning of the twelfth century. Henry I (1100-1135) granted the citizens of London a "custodiendum placitae coronae" (custodian of the crown pleas).[7] According to Gross, who wrote a fine history of the coroner,[8] the terms "custodes placitorum coronae" and "coronatores" (coroners) were used interchangeably up to the year 1250.[9] Hunnisett, today's leading historian on the English coroner, has meticulously documented that the duties of the latter day coroner were essentially the same as those performed by the county justiciar in the reign of Henry I.[10] Further proof that the office of the coroner existed prior to the Articles of Eyre in 1194 includes a murder case which involved the local coroners and probably took place in 1189 or 1190 but was not brought before the justices of Westminster until November 1194.[11] Thus at some point, the "justiciar" became the "coroner" (a distinctly English office),[12] and it is clear that the Articles of Eyre in 1194, although the first undisputed reference to the coroner,[13] pertained to an office whose functions were already well established.

There were several reasons to establish the office of coroner. Some[14] have asserted that the office was inspired by the twenty first chapter of Deuteronomy:

> If there be found a slain person in the land which the Lord thy God giveth thee to possess it, lying in the field, and it be not known who hath slain him; then shall

> thy elders and thy judges go forth unto the cities which are round about the one that is slain.

Far more generally agreed upon is that after the Norman Conquest, new laws and revenues were necessary to establish order and run the new government. Illustrative of this principle is "Lex Murdrorum." Under this law, from which the word murder originated,[15] a severe fine was imposed upon any community in which a Norman was murdered or died unexpectedly. Any person who died in such a manner was assumed Norman until proved to be English. This set a precedent for the coroner to investigate deaths arising under unusual circumstances and often resulted in financial reward for the Crown, while it discouraged the murder of Normans.

There were other excellent reasons for the firm establishment of the "keeper of the pleas of the Crown" by the Articles of Eyre in 1194. Richard had spent heavily in the wars of the crusades and many of the English sheriffs, the leading county officials, had been involved in John's challenge to the throne.[16] County coroners insured that local Crown revenues were recorded in the many feudal estates and duly awarded to the king. They also usurped some of the sheriff's power and kept them in check. The coroner thus owed his origin to new rulers with new laws, a growing central government in need of a local representation, and the need for increased revenues.

Judged from the list of duties the coroner performed, the office was essentially that of a tax collector. Since felons forfeited lands and chattels to the king, the coroner was involved in many aspects of criminal law. The coroner was responsible for initial proceedings in all "appeals," which were private suits for prosecution of a felony, since there was no "public" prosecutor. The coroner recorded the accusation, and if the case were successful before the hundred court[17] (the county court) and subsequently before the Eyre (the itinerant court) the felon's lands and chattels were forfeited to the Crown and the felon punished.[18] An appeal could pertain to an alleged homicide, rape, robbery (called "housebreaking"), arson, or wounding.[19] If the private party dropped the suit before final hearing at the Eyre, the appealor was fined.[20] The coroner also recorded confessions of felons and approvers' appeals. Approvers were felons who "appealed," that is, turned states evidence by implicating their accessories. A successful appeal resulted in the conviction of the felon's accomplices, pardon from execution for the primary felon (with the opportunity to buy a full pardon), and forfeiture of lands and chattels to the Crown of all felons.[21] In all court proceedings, if witnesses, defendants, appellors, approvers, or any person involved with a case failed to appear in response to a summons, the court could in a series of steps outlaw the truant. The coroner recorded the outlaws

and committed the lands and chattels of the outlaw to the Crown. The community from which an outlaw fled was also fined.[22] Until abolished in 1483, forfeiture of properties of suspected felons as well as convicted felons was the usual practice.[23] Forfeiture of properties of convicted felons continued until 1870.[24]

The coroner also investigated wrecks, royal fish (whale and sturgeon), and treasure trove. These were valuable perquisites of the Crown. Treasure trove was money found by accident. This, by English common law, at first belonged to the finder but later came to belong to the king, with concealment conferring a death sentence.[25] Royal fish and shipwrecks nominally also belonged to the king. These latter, however, according to Hunnisett, rarely concerned the coroner because these perquisites had largely been granted to individual lords within their fiefdom.[26]

One of the coroner's most interesting duties dealt with abjurations of the realm, an oddity of medieval justice. Any felon who fled to a consecrated church was safe in this sanctuary for a given number of days, usually forty, and would be fed for that time by the local community. It was the coroner's duty to visit the refugee and offer him a choice between surrendering to trial or abjuring the realm. The community's duty on penalty of fine was to guard the sanctuary to prevent escape.[27] At the end of the allotted time, the felon would be starved into submission. If the

felon chose to abjure the realm, his chattels were forfeited to the Crown, and the coroner directed him to go by a set path to a port and attempt every day to sail from England. If the sea did not permit a boat's passage, the felon walked into the sea every day demonstrating his desire for exile.

> As felon of the King, and because many mischiefes and robberies I have committed, I abjure this realm, and I ought to haste me to the Port from such place as you have appointed me, nor ought I to divert to any other way, and if I doe, I will that I bee taken as a Theefe and Felon of the King, and that at such a Place I will seek diligently my passage, and will not expect but one flow and ebbe, if I can passe, and if in such space I cannot goe over, I will goe every day into the sea up to my knees, and try to passe. . .[28]

His thumb was branded and any deviation from the prescribed course resulted in execution.[29]

The majority of the coroner's time was involved with inquests on the dead. Part of this was due to the highly profitable "Lex Murdrorum." But the coroner also investigated all deaths from suicide, homicide, and mischance as well as any suspicious death or deaths in prison. Early law books stated that the coroner should hold inquests regarding wounding, rape, housebreaking, and prison breaking too. Hunnisett, however, points out that the coroner never held inquests into any of these matters and that the early writers (Bracton and Britton) misled themselves and many subsequent scholars by confusing inquests with appeals and abjurations.[30]

The overall sequence of events surrounding an inquest held many opportunities of financial gain for the Crown. When a body was discovered, the witness to the death or the "first finder" of the body was to raise a hue and cry, and the first four persons ("nearest neighbors") to the scene were to report to the bailiff and coroner. All these persons were attached and sworn, each with two other people as sureties, to attend the inquest and next Eyre (itinerant court). Furthermore, often the whole household where the crime was committed were ordered to attend. If the hue and cry was not raised, if any person neglected to attend the inquest or Eyre, if the felon responsible escaped by daylight (they almost always escaped "at night"), or if the body was buried or moved, fines were allotted.[31] If a suspicious death were not reported, the community was fined. Hunnisett cites examples where the community requested the coroner to hold inquests in cases of natural deaths for fear of being fined.[32] In all inquests, there was almost certainly some money gathered for the Crown. The coroner himself had no power to impose amercements (fines), but he recorded all facts, and the courts imposed the fines based on the coroner's reports.[33]

When notified of the deceased, the coroner was to begin the inquest immediately. Almost always, the inquest was completed within three days of the victim's death.[34] The day the coroner was notified, he would view the body,

arrest suspects, assess belongings subject to forfeiture, and instruct the bailiff to summon a jury for a certain day and place. The jury also was required to view the body, preferably where found (there was a fine if the body was moved), and inspect it for marks of violence. Other than viewing the naked body, no further attempt was made to establish a cause of death and autopsies were almost totally unknown in England until the latter half of the eighteenth century. The jury would record the length, breadth, and depth of any wounds found. The body was then buried and the jury adjourned to a guildhall or public house to continue the inquest.[35]

Because of "Lex Murdrorum," it was necessary to prove in every instance that the deceased was English. This proof was normally presented to the coroner's jury by two relatives of the deceased. These same relatives needed also to present Englishry at the County Court and Eyre, or be fined. If the deceased were unknown, the community incurred the heavy fine of "Lex Murdrorum." The jurors next had to establish the details regarding the death, render a verdict, decide what need be forfeited, and determine the deodand. If the verdict was suicide or "felo de se" (a felony to oneself), it entailed not only the stigma of financial losses to the Crown, but also meant the body could not be buried in hallowed ground.[36] A deodand was the inanimate object that was the immediate cause of death,

and was forfeited to the Crown. Originally, the deodand was a gift to the Church to expiate its sins,[37] but in Norman times, the deodand became the right of the Crown. Technically, "all things moving with the thing that is the occasion of death, shall be forfeit,"[38] and therefore if a man were run over by a cart wheel while the cart was in motion, the whole cart was the deodand.[39] In practice, the jury often only assessed the cart wheel, or they would vastly undervalue the deodand, while reserving the right to occasionally impose the full value. Generally though, the deodand was assessed to be worth only a few shillings and the owner paid the cost.[40]

The jury might be twelve to fifty in number, made up of common folk from the nearest four townships, but was usually twelve to twenty-four persons. These local men often knew much about the circumstances of the death already and made further inquiries before the inquest.[41] These early inquests usually included the first finder, witnesses, and relatives who would prove Englishry. This procedure was far more advanced than that of the petty jury established at least a half century after the coroner's jury. The petty jury based its verdict on previous knowledge of facts without benefit of witnesses or others not on the jury.[42]

The inquest, for its time, was an advanced institution. Hunnisett cites several examples of a medieval coroner holding a second, even a third inquest on the same body, each with new jurors and a record of all the verdicts.[43] Britton says of the coroner, "If there is need of further inquiry, and that by others, let the inquiry be made again and again."[44] Furthermore, in the latter half of the thirteenth century, the coroner's jury generally was supplemented by a jury of twelve freeman of the hundred. Both juries were required to attend the Eyre and the freeman jury often also tried the case with the petty jury at the Eyre.[45] In this way, part of the coroner's jury provided some of the personnel for the early petty juries[46] and provided a basis for the modern jury system.[47]

Coroners were appointed or elected. The county coroner was elected by knights and freeholders of the shire. Franchisal coroners appeared a little later, just after 1200, and were authorized either by royal charter or by proof that the coroner had already been "in long and continuous use."[48] Many lords of large liberties already had rights to the revenues of "Lex Murdrorum" as well as treasure trove and shipwrecks. Therefore, the king lost little financially and curried favor from the lord by granting him the right to appoint a coroner. The majority of the coroners, however, were elected county coroners with allegiance to the king. The only requirements were that the coroners were to be

chosen from "none but lawful, most wise and discreet, knights,"[49] and to own properties in the county which could be held accountable to ensure that the coroners properly perform their duties. The coroners' districts were initially indistinct and variable depending on the location of the coroners' lands and disposition to travel.[50] The coroner was elected in theory for life or for good behavior and his office was not discontinued with the death of the king.[51] However, Hunnisett found that special writs to hold re-elections commonly appeared shortly after each new reign in the fourteenth and fifteenth centuries.[52] The coroner could be replaced only because of death, infirmity, appointment to another post or inadequate qualifications. There was no obligation for the coroner to have legal or medical expertise. Hunnisett notes that William de Hastyngge, a medieval Sussex coroner and a surgeon, was probably the first medically trained coroner.[53]

Britton claims sheriffs often supplied false information to depose troublesome coroners, but a writ of supersedeas replaced the coroner once the charges were disproved.[54] This was indicative of the check and counter-check roles the coroner and sheriff played. Again, one of the theories for establishing the coroner was to provide the Crown with a local intermediary who could help control the sheriffs, who often bought their office and used it for private gain.[55]

Coroner's reports sometimes led to fines on the sheriff[56] and the coroner kept records of lands and chattels forfeit to the Crown and entrusted to the custody of the sheriff. The sheriff, on the other hand, supervised the election of the coroner, often decided when the coroner was to be replaced, and kept his own duplicate rolls of Crown pleas for use in any dispute of the coroner's rolls.[57]

The major defects in the coroner system were that the office was unpaid, entailed much travelling, and often incurred personal fines. While the coroner was a knight (knighthood required enough land to yield twenty pounds per year), the coroner could afford to live without further income. However, the job was not attractive, and could not compete with the numerous other positions created in the fourteenth century, such as justice of the peace and escheator, each of which required knighthood. Thus, by the fourteenth century, there was a shortage of knights and a coroner with knighthood was a rare exception.[58] Later it was considered sufficient that the coroner "have land in fee sufficient in the same county whereof he may answer to all manner of people."[59] This was regarded to be lands yielding about 100 shillings per year[60] and knighthood in the office became obsolete.

The coroner was at the height of his power in the twelfth century. However, because of the lack of knighthood, pay, or personal wealth, the coroners became more

inclined to consider extortion as a perquisite of the office.[61] Wilkinson wrote in 1651 "that people of small consideration, and not of the wisest, be now lately chosen to the office of Coroners, and much meeter it were, that wise men, loyall, and sage, should intermeddle with that office."[62] Furthermore, many of the coroner's duties fell into disuse and his power diminished. Eyre was discontinued shortly after 1300 and with that many of the revenues the coroner had supervised disappeared. "Lex Murdrorum" was repealed in 1340, partly because there was no longer an Eyre to impose the fines, but especially because England was at war with France.[63] Abjurations and appeals became less and less frequent, and were extinct by the sixteenth century.[64] Inquiries regarding wrecks or royal fish rarely ever concerned the coroner and were repealed in the Coroners Act of 1887. Treasure trove is still legally a concern of the coroner, but the escheator since the fourteenth century has largely usurped the coroner's role in this regard. Outlawry, while still practiced into the sixteenth century, had largely lost its meaning with the termination of the Eyre.[65] Lastly, "the keeper of all the pleas of the Crown" failed to expand his role as the range of Crown pleas grew in the middle ages. Part of this limitation of duties was due to the new justices of the peace, established in 1380, who were responsible for the indictments of felons and determined punishments. Thus, the justices of the peace took over

duties involved with felonies the coroner had dealt with previously, and the escheators took charge of monies and goods forfeited to the Crown.[66]

The coroner's sole responsibility remaining through the centuries was the inquest on deaths due to homicides, suicide, mischance, occurring under suspicious circumstances, or in prison. Finally, in 1487, the coroner was paid a fee of thirteen shillings four pence for each inquest upon a person slain or murdered.[67] However, few of the coroners' inquests were homicides.[68] A further statute[69] in 1509 specifically stated there was to be no fee for inquests concerning misadventure but that if the coroner did not do his duty in all cases he would be heavily fined. This statute had become necessary because misadventures had largely been neglected when coroners were paid for other inquests.[70] No significant reform occurred until 1751, when a statute[71] insured payment for all inquests and also provided a mileage allowance. In 1836, the coroner was budgeted to pay medical witnesses and to pay for post mortem examinations. In the same year, Britain legislated the Births and Deaths Registration Act which would provide the first accurate nationwide census and analysis of causes of death.[72]

The coroner's investigation of inquests, except for budget reforms, was largely unchanged from the twelfth to the eighteenth century. The coroner was established

originally for financial reasons and in order to have a royal emissary at the local level. The establishment of the justice of the peace and the escheator kept the coroner from growing and changing with the times. Yet the coroner in his intermediary role was a check to feudalism in medieval times and the coroner's jury may have been a prototype for the early petty juries and set precedents for English court procedure. Furthermore, the inquest at its best was an institution of integrity seeking facts to ensure justice and, for many centuries, the inquest provided the only available detailed information regarding deaths, an early forerunner of formal vital statistics.

WESTMINSTER CORONER INQUESTS

The series of Coroners' Inquests and papers held in Westminster Abbey, London, are a remarkable collection. Little has been written about the coroner and the wealth of facts he recorded in his inquests. Wellington states there are only 260 rolls preserved documenting the activities of the medieval coroner and they are scattered throughout the period with numerous gaps.

Henry III: Rolls 1, 2, 46 (Bedforshire).[73]
Edward I: Rolls 3-4, 106, 107, 128, 208, 254-256.
Edward II: Rolls 6, 47, 94A, 106-110.
Edward III and Richard II: Rolls 47, 60, 61, 145, 147, 162, 166.
Henry IV and Henry V: Rolls 60-63, 101, 145, 147-151, 162, 166-170, 253.
Henry VI: Roll 158.

Rolls are not the original inquests but merely summaries transcribed for the Eyre to document chattels, lands, and other monies due the Crown.[74] Later, with statutes allowing the coroner a fee for inquests, rolls became more regular.[75] However, collections of complete coroners' inquests are relatively rare and studies to date, other than case reports of one or two inquests, are few in number. One small collection in Nottinghamshire between 1485 and 1558 was studied by Hunnisett.[76] Bailey, though, was the first to bring to light the original inquests complete with witness depositions (testimony). Unfortunately, this series consisted of only 60 cases for the period 1746-1789.[77] More recently,

Forbes has published a study on original complete coroners inquests with depositions for 6,351 cases over the period of 1788-1826.[78] With only these few existing studies, the collection at Westminster Abbey is indeed remarkable; the Abbey houses approximately 20,000 complete, original inquests with depositions in a continuous series from 1761-1879.

In this investigation of coroners' inquests, 2687 cases were studied over four time periods. Four model periods were chosen to document changes in procedure, attitudes, and statistics over the century: 1761-1765, 1800-1803, 1835-1838, and 1865-1866. The first period is five years due to the smaller number of inquests in those years, and the last period only two years because of the tremendous growth in the number of inquests. The parishes under the jurisdiction of the Westminster coroner remained constant in number and location during these periods.[79] The Westminster coroners dealt with a growing population in a constant area.

Westminster Abbey holds these documents because the City of Westminster had a franchisal coroner, appointed by the Dean or Abbot of Westminster Abbey. The coroners' documents were then the property of the Abbey. After 1880, Westminster elected a Lord Mayor and coroners' records and documents were sent to him. This explains why the Abbey's documents end in 1879.[80]

The coroners encountered in this study were the following, with their dates of office:[81]

John Feary, ? - 1762
Thomas Prickard, 1762 - 1792
Anthony Gell, 1792 - 1816
John Henry Gell, Esquire, 1816 - 1845
Charles St. Clare Bedford, Esquire, 1845 - 1888
and his deputy, S. F. Langham

All were appointed by the Dean and Chapter of Westminster Abbey and were officially coroner for the "City and liberties of Westminster."[82] Hunnisett mentioned that in earlier centuries, coroners were often replaced shortly after the ascension of a new monarch.[83] John Feary was replaced slightly more than a year after the ascension of George III, but the dates of office of all the other coroners bear no relationship to the transfer of the Crown. This may have been because of franchisal status. Not much is known about John Feary, but from the other coroners a few generalizations can be made.[84] Thomas Prickard had been secretary to the Bishop of Chichester and Rochester prior to his appointment as coroner. Anthony Gell was employed at the Abbey for some time before becoming coroner, and John Henry Gell was Westminster College Auditor at age 24, as well as being the son of Anthony Gell. All four coroners from Prickard to Bedford were Receivers General, usually before becoming coroner. Prickard, appointed coroner in 1762, was appointed Westminster Receiver General jointly with Anthony Gell in 1787. Later in 1801, Anthony Gell was coroner and a new patent as Receiver General was issued to him jointly with his son John Henry Gell. Bedford did not hold a joint appointment with John Henry Gell but assumed the position shortly

before Gell's death. Thus, the positions of coroner and Receiver General were closely linked and often assumed the appearance of an apprenticeship with joint appointments between successive coroners. This natural succession is similar to that found in the sixteenth century when the Nottinghamshire coroners repeatedly followed the pattern of holding the offices of chamberlain, sheriff, coroner, and mayor in sequence.[85] Furthermore, like the Nottinghamshire coroners, none of the Westminster coroners died in office, but resigned one to nine years before their deaths. The ages at death from Prickard to Bedord were 70, 71, 85 and 90 respectively. Prickard and Anthony Gell are buried in Westminster Abbey.

It is not known if any of the Westminster coroners had legal training but the office of Receiver General required some legal knowledge (as did that of the coroner) and there were some Receiver Generals who were attornies in the eighteenth and nineteenth centuries.[86] None of the Westminster coroners had medical training. The first medically trained coroner, other than a reputed "surgeon" in medieval times that Hunnisett discovered in Sussex,[87] was Thomas Wakley, coroner for the city of London in 1839.[88] The coroner was not required to have legal or medical training until 1926, though by the latter half of the nineteenth century, such expertise was becoming common.[89]

One puzzling aspect of the Westminster coroners was that they might not have all owned land "in fee sufficient in the same county whereof he may answer to all manner of people."[90] Presumably, they all owned some land nearby to house their families. However, they could have rented or been residents of the Abbey, which was likely given their multiple appointments. Prickard was Welch and his will mentioned property in Wales. This could indicate that as franchisal coroners they were exempted from both election and land requirements, which were the two mainstays for the qualifications of a county coroner. One of the original reasons for the land requirement was to ensure that the coroner was able to support himself; now that the office was paid, this requirement was less important. The coroner in these periods studied was paid twenty shillings per inquest and allowed nine pence per mile travelled in the performance of his office.[91] Accounts exist documenting that John Henry Gell earned 115 pounds for holding eighty-three inquests between December 1837 and March 1838.[97] His annual income would be in the neighborhood of five hundred pounds.[93]

The Westminster coroner investigated felonious, accidental and sudden deaths, as well as all deaths that occurred within the prisons situated in Westminster. Bracton and Britton specifically stated coroners should also hold inquests into wounding and mayhem. Britton defined mayhem

as that "where any member of a man is taken away, whereby he is the more unable to fight, as if the eye, the hand, the foot, or by bruising of the head, or knocking out of the foreteeth, but cutting off the ear and nose is no mayhem but a blemish of the body."[94] As was mentioned earlier, Hunnisett found no instances of an inquest into wounding or mayhem unless the wound resulted in death, and felt the writers of law books and early treatises on the coroner were misled by the coroner's involvement with appeals.[95] The only possible case of mayhem investigated in this series of inquests was a riot which resulted in a death.

> An Inquisition Indented taken for Our Sovereign Lord the Kind at the Parish of Saint Anne. . . on view of the Body of William Davy there and then lying dead /the jurors/ duly sworn and charged to inquire for our said Lord the King, when, how and by what means the said William Davy came to his Death, do upon their Oath say, That divers persons dressed in Sailors Habits to the Jurors aforesaid as yet unknown. . . being riotously and tumultuously and unlawfully assembled together in open Breach of the Publick peace, and terror of this Majesty's good Subjects, and having violently tumultuously and unlawfully assaulted and Battered the dwelling House of Thomas Kelly Victualler situate in Holywell Street. . . with Sticks Bricks Tiles and other Instruments with intent to demolish and pull down the said House, and that by the desire of two of His Majesty's Justices of the Peace, a Lieutenant and several Soldiers. . . assembled before the House of the said Thomas Kelly in order to disperse the Mob and to prevent further Mischief, And that the said Persons unknown, so tumultuously riotously and unlawfully then and there assembled, not dispersing themselves but continuing together, and likewise continuing to assault the said House and also Assaulting the Persons of the said Soldiers with Sticks Bricks Tiles and other Instruments, thereby putting the said Soldiers

> in defense of themselves, and for the Preservation of their own Lives, and of the Life of the said Thomas Kelly, and also to prevent the Destruction of the said House, their several and respective Guns, commonly called Firelocks, charged with Gunpowder and leaden Bullets, at to and against the said several Persons unknown, so riotously tumultuously and unlawfully then and there Assembled together did discharge and shoot off, and that it so happened that Casually and by misfortune one of the said Bullets so shot out of one of the said Firelocks as aforesaid, by one of the said Soldiers. . . did give unto him the said William Davy, then running towards and being near to the said Persons so riotously, tumultuously and unlawfully assembled together as aforesaid, one Mortal Wound in and upon the Body of him the said William Davy, near the Navel, of the length of one Inch and of the depth of Four Inches, of which said Mortal Wound he the said William Davy died the same Day.[96]

The official verdict for the death of the shot bystander was "chance-medley," or accidental homicide. There were no cases of wounding without ensuing death.

Generally, according to evidence presented by witnesses, friends, and medical men, a verdict was reached of murder, manslaughter, chance-medley, infanticide, suicide, accident, illness or natural death. The only cases in which a verdict was not reached was when the deceased was unknown or occasionally in cases of infanticide. These cases were "found dead" or "found drowned." Hunnisett noted, in his study of Nottinghamshire inquests of 1485-1588, that an unequivocal verdict regarding the cause of death was given in all cases unless the victim was unknown.[97] However, in later years, coroners' juries often equivocated in cases of infanticide

because of the impact of such a decision. According to law not repealed until 1803,[98] a woman was guilty of murder if she concealed an illegitimate stillborn birth and could not prove it was stillborn. This was to discourage infanticide, highly distressful to the Catholic Church (the law was passed under James I). The law gave the jury the difficult decision of determining whether a newborn had been stillborn or died shortly after birth. Medical expertise was not far advanced at this time and jurors understandably hesitated rendering a verdict of murder.[99] In cases of infanticide, even though all persons and circumstances might be known, the jury's verdict was not infrequently "found dead but as to cause of death there is not sufficient evidence to say."[100]

Another variation on the range of verdicts was "felo de se /a felonious suicide/ not having the fear of God before his Eyes but moved and seduced by the Instigation of the Devil and of his Malice forethought did kill and Murder himself." The alternative verdict was lunatic suicide, if the victim were "not being of sound mind memory and understanding but lunatic and distracted." The distinction was important if the deceased were not to be declared a felon and forfeit goods, chattels, and lands. Furthermore, a verdict of "felo de se" dictated burial under a highway in unhallowed ground.[101] Nearly all of the suicides in these inquests were declared lunatic suicides. In the few cases of "felo de se," there were warrants issued to the constables

and churchwardens of the parish. In 1762, the warrant was handwritten, but in 1801, the warrant was printed with spaces to be filled in for name of the deceased and specifics. The wording is nearly identical and on the back side of each warrant is written where the victim was buried and signed by the constables and churchwardens.

> Whereas by an Inquisition taken before me the Day and year hereunder written on View of the Body of Elizabeth Beck at the parish of Saint John the Evangelist in the City of Westminster in the County of Middlesex the said Elizabeth Beck was found guilty of Self-Murder. These are therefore in his Majesty's Name to charge and command you that you cause the Body of the said Elizabeth Beck to be buried in the King's publick highway and that you make a due Return to me how and in what manor you have caused the said Elizabeth Beck to be buried. And for your so doing this shall be your warrant Given under my Hand and Seal.[102]

The law requiring burial of suicide victims under a highway was repealed in 1823[103] and there were no warrants found among the inquests in the last two periods.

How the coroner proceeded in an inquest had changed very little through the centuries or during the century studied here. In Westminster, the coroner was acquainted with the information that a death needed investigation by the constable. No documents exist for the earlier periods, and by 1865, each parish had its own printed form. Some were called "Notice of Death" and others "Application for a Warrant for an Inquest," depending on the parish. These generally supplied the coroner with the name, age and

occupation of the deceased, whether there was evidence of violence or illness before death, and the time and place of death. The "first finders" were no longer attached,[104] and the names of witnesses were included in the report, and the name and opinion of any medical man who may have been involved. By 1865, it was common to have a note from the medical man accompanying the police notification form. One example from 1865 is the following:

Mount St. Dead House
March 8th 1865

> I have examined the dead body of a newly born male child, brought in this morning--there are no marks of violence, nearly the whole navel-string, which has been cut and not tied, remains.
>
> Cannot state if child has lived without internal examination.
>
> Wm. Bloxam M.D.[105]

Very rarely, the medical man initiated the inquest. In 1865, John Welsh, a Surgeon, attended a dying woman and felt the circumstances warranted investigation. He wrote a letter to Coroner Bedford.

> Sunday morning at 1/2 past 10 I received an order to attend upon Hannah Mason age 45.
>
> I found her insensible, lying on a filthy bed, she was almost pulseless--breathing torturous--pupils contracted--she died this morning--I saw from the first that her case was hopeless.
>
> She had been since Monday in this condition; she had never spoken since then--and yet she was left in this state, totally uncared for--

> The woman had no medical or nurse attendance whatever--the case is one of great neglect. . .
>
> I saw her 3 hours yesterday--I ordered her Brandy--stimulating medicines. . . /later/ I found the Husband quite drunk--the Brandy bottle quite empty--I do not believe the poor woman had one drop of the Brandy--. . .
>
> I consider the case one calling for an Inquiry, as the woman seemed to have been totally neglected.
>
> Welch M.D.[106]

After establishing the facts and need for an inquest, the Westminster coroner issued a warrant to the bailiff or constable to summon a jury. The warrants were often included in the inquest, always printed on paper with spaces to fill in details, and were signed by the coroner accompanied by a seal. The wording was identical throughout the century.[107]

> To the Constables of the Parish of _____ within the said Liberty of Westminster.
>
> By Virtue of my Office, these are in his Majesty's Name to charge and command you, that on Sight hereof you summon and warn Twenty-four able and sufficient Men of the said Liberty, personally to be and appear before me on _____ the _____ day of _____ by _____ of the Clock precisely, in the _____ noon of the same Day at _____ then and there to do and execute all such things as shall be given them in Charge, on the Behalf of our Sovereign Lord the King's Majesty, touching the Death of _____ and for your so doing this is your Warrant. And that you also attend at the Time and Place above-mentioned, to make a Return of the Names of those you shall so summon: And further to do and execute such other Matters as shall be then and there enjoined

you, and have you then and there this Warrant given under my Hand and Seal this _____ day of _____ in the year of our Lord _____

_____ Coroner /Seal/

The "return" made to the coroner was a jury list including names, addresses, and occupations of all summoned. These variably survived with the inquests studied. According to the available jury lists, the constable must have walked down a street and knocked on doors summoning a jury because a series of jurors would all be from the same street. Generally, the constable summon 24-30 potential jurors and the coroner swore in about 14. The coroner had the sole authority to choose which jurors to swear in.[108] Among these jurors, a foreman was chosen and the inquest would begin. This generally all transpired within two days from when the body was found. However, in 1865, the average delay between death and inquest averaged four days, and occasionally was up to nine days. This delay was most likely due to the tremendous increase in cases that occurred over the century, and even with the deputy coroner present in 1865, it was difficult to handle all the inquests efficiently. In one inquest, the following note was found:

Dear Langham /deputy coroner/,

Can you conveniently take the case this afternoon? I have had a troublesome case this morning and I have another at 5--it will be a relief to me to get rid of the 3 pm--I am here and ready should it put you out.

yours,
Bedford[109]

The majority of jurors were occupied in trade and few were laborers. Almost any man might be the foreman, though a grocer, victualer, pub owner, or tailor were most frequent. However, these trades were highly represented on the jury. On one jury in 1865, ten tailors were sworn.[110] This probably occurred because of the close proximity of many tailors on the street where the local constable summoned the jurors. The jury lists taken together probably represented an accurate cross section of trade in urban Westminster. According to Registrar General statistics,[111] Westminster had 25,000 families in 1801 and 30,000 in 1831 employed in trade.

At the same time, agriculture decreased from 255 families to 119 families, and 16,000 to 20,000 families were employed as laborers or servants. The jury lists did not include any farmers, perhaps because there were few in the community. More significant was the rarity of jurors who were servants or unskilled laborers.

Among the 1835 inquests was a form listing the required qualifications of a juror. The man had to be between the ages of twenty-one years and sixty, a natural born subject of the king, and fulfill the following financial qualifications:

> Possessed of an Income of £10, per Annum or upwards, arising from Freehold Property, situate in this County: or
>
> Possessed of an Income of £20, per Annum or upwards, arising from Leasehold Property, situate in this County: or

OCCUPATION	1761 *J/F	1800 *J/F	1835 *J/F	1865 *J/F
Artist	--	--	--	3/1
Auctioner	--	3	1	2
Baker	10	52/3	45/2	27/1
Book-maker,-printer,-seller	--	19	4	13
Brewer	3/1	1	2	--
Butcher	4	20/1	28/1	25/2
Carpenter	1	27/2	9	33
Chandler	22/1	31	12/1	6
Cheesemonger	6	47/3	20/2	4
Chimney sweep	1	--	--	1
Coal Dealer	2	21/1	8	3
Currier	--	2	3	1
Cutter or Carver	--	13	3	2
Dealer (tea, ham, corn, etc.)	--	--	26/3	23
Decorator	--	--	--	11/2
Draper (linen, woolen)	3	16/2	3	13/1
Dyer & fabric merchants	--	11/2	3	3
Fishmonger	--	13/1	5	10
Fruiterer	1	4	--	1
Furrier	--	2	3	2
Glazier	3/1	15/2	6	--
Grocer	18	69/2	51/3	84/4
Hair Dresser/Barber	3	26/1	12/2	10
Hatter/Haberdasher	9	18	6	6/1
Hosier	--	7	2	3
Jeweller	1	3	1	6
Laborer	1	19/1	7	3
Maker (cabinet, pipe, toy, etc.)	19/1	58/3	27/2	39/1
Metal worker (tin, silver, etc.)	3	13	15	13
Milkman/Dairyman	--	3	8	32/2
Oyleman	1	5	19/2	1
Painter	1	3	3	2
Pawn Broker	9	24/1	22	2
Perfumer	--	7	--	2
Peruke maker	7	2	--	--

*J/F=number jurymen and number foremen

OCCUPATION	1761 *J/F	1800 *J/F	1835 *J/F	1865 *J/F
Plumber	1	2	4	5/1
Poulterer	--	10	4/1	3
Publican (pub owner)	5	20/4	16	25/1
Saddler	--	7	3	10
Salesman	--	4	8	3
Servants and Cooks	--	12	--	7
Shoemaker	8	62/1	17	48
Shops (clothier, china, etc.)	4/1	15/2	12	1
Smith	1	20	8	6
Stable keeper	--	2/1	2	3
Stationer	2	5	2	13
Taylor	2	38/2	13/1	84/3
Tobacconist	--	7	--	11/1
Turner	2/1	5/1	1	--
Undertaker	--	4	2/1	4
Upholsterer	--	--	1	4
Victualer (Inn keeper)	30	151/3	49/2	115/3
Vintner	4/2	35/1	2	13
Watchmaker	4/1	4/1	2	16/1
Gentleman	--	9/2	1	15

*J/F=number of jurymen and of foremen

Note: These were compiled from nine jury lists available in 1761-1765, forty-three lists in 1800-1803, twenty-three lists in 1835-1838, and twenty-six lists in 1865-1866.

> Being a Householder in this Parish, rated to the Poor Rate at not less than £30, per Annum: or
>
> Being a Householder in this Parish, rated to the Inhabited House Duty, at not less than £30, per Annum: or
>
> Occupier of a House in this Parish with not less than 15 Windows.[112]

This would explain why most of the jury were successful businessmen. There was a remarkable lack of professional men on the jury, largely because many were exempt. These exemptions in 1835 were:

> Peers and Judges of the Courts of Record at Westminster.
>
> Clergymen in Orders, and Roman Catholic Priests.
>
> Ministers of any Congregation of Protestant Dissenters.
>
> Serjeants and Barristers at Law, Members of the Society of Doctors of Law, and Advocates of the Civil Law, actually practising.
>
> Coroners, Gaolers, and Keepers of House of Correction.
>
> Members and Licentiates of the Royal College of Physicians in London, actually practising. Apothecaries, certificated by the Court of Examiners of the Apothecaries' Company, and actually practising.
>
> Officers in His Majesty's Navy or Army, on full pay.
>
> Pilots licensed under any Act of Parliament or Charter for the regulation of Pilots in any other Ports.
>
> Household Servants of His Majesty.

Officers of Customs and Excise, Sheriff's Officers, High Constables, and Parish Clerks.

And Persons exempt by virtue of any Prescription, Charter, Grant, or Writ.

Regardless of these exemptions, an Infirmary Surgeon was summoned in 1865 and a beadle was summoned for jury duty in 1801. Neither served. However, a few "gentlemen" did jury duty on rare occasions. Of the jury lists available, nine gentlemen served on juries in 1800, one in 1835, and fifteen in 1865. Often, these gentlemen served on the same case. For example, in 1800, Sir Godfrey Webster shot himself and the jury included three gentlemen, one of whom was foreman.[113] The verdict was lunatic suicide. A very few professional men did serve on the jury, including a veterinary surgeon who was also the foreman, two chemists, and a schoolmaster, all in 1865.

It was sometimes difficult to convene the inquest because jurors did not answer their summons. In one inquest in 1801,[114] two letters are found excusing jurors from duty; and in 1865, two jurors were excused by their doctors because of illness.[115] In another case, the inquest had to be rescheduled because the original jurors did not attend.[116]

Because it was difficult to get qualified men, the coroner usually kept the same jury if there were more than one inquest in one day.[117] This never happened in the 1760 period, but by 1800, three unrelated inquests were held on

one day and two were not uncommon. The jury most often met in a nearby public house.[118] This might be the "House of Mrs. Grant at the sign of the White Horse on Castle Street." The inquest was almost always held in a public house in 1760. By 1800 and 1835, the inquests were occasionally held in the parish workhouse, especially if the victim were an inmate of the workhouse or had died on the streets, in which case the dead body was normally carried to the "dead house" provided by the parish workhouse. In these periods, the Westminster hospitals also provided facilities for inquests when the victim died in the hospital. Thus, through the century, the inquests gradually moved from the "pub" to the public meeting halls. By 1865, the majority of inquests were held in hospitals and parish vestry halls.

After being sworn in by the coroner, the first duty of the jury was to view the body of the deceased to note any marks of violence, carefully measuring the breadth, depth, and width of all wounds. On more than one occasion, a juror had to be excused "as unwell of the viewing the body."[119] The body of the deceased had to be present wherever the inquest was held. The inquest strictly was convened "on view of the body," and the corpse, along with the coroner, the jury, and the witnesses constituted the participants of the inquest. This was so important that the coroner had to issue an order to disinter the body had the

deceased been already buried. Disinternment occurred in several inquests of this series.[120] In practice, however, the body was often in a separate area, most frequently the dead house, a building provided by each parish to receive the dead. This was where the jury "viewed" the body and most autopsies were performed. In 1865, Coroner Bedford wrote the authorities of the Parish of St. Margaret to acquaint them with

> the feelings of the jury, the relations of the deceased man, and all present having been greatly excited and strongly expressed, on viewing the body at the /dead house provided by the Parish/, and I will only ask that an inspection of the place be made to satisfy you that my complaint is not groundless--and that proper respect for the dead has been lost sight of which I am confident the authorities of the Parish would not permit.[121]

After the jury viewed the body, the coroner would decide whether to issue a warrant for a post morten, and then the body was buried by the coroner's warrant of internment. The jury then continued the inquest without the deceased.[122]

Other important participants at the inquests were the witnesses and relatives of the deceased. The pertinent witnesses were generally selected by the beadle, and the coroner sent out their summonses. The warrants issued by the Westminster coroners charged the witness to attend "to give Evidence and be examined on his Majesty's behalf touching the Premises. Hereof, fail not, as you will answer the

contrary at your Peril."[123] If a witness failed to answer a summons, the coroner would issue a warrant for his arrest;

> therefore by virtue of my office in her Majesty's name, you /the Constable/ are without delay to apprehend and bring before me one of her Majesty's Coroners for the said City and Liberty of Westminster now sitting at the Parish aforesaid by virtue of my said office the body of the said /witness/ that he may be dealt with according to law and for your so doing this is your warrant.[124]

In cases of homicide, it was not infrequent for the coroner to require a future witness to post bond. In the case of a duel in 1764, the coroner required forty pounds apiece for two witnesses to ensure that the witnesses attended the inquest and also "in Case the Bill of Indictment shall be returned, a true Bill, to give Evidence on the trial of the /defendant/."[125] In another duel, eight witnesses, one of whom was a surgeon, posted bonds of sixty pounds. One gentleman was singled out for a bond of 200 pounds, "to prosecute and give evidence."[126]

Some witnesses were eager to attend, and this most frequently involved suicides where it was important to convince the jury that the deceased was "lunatic and distracted" shortly before his death. In 1865, Bedord received this note:

> Dear Sir,
>
> A lamentable occurrence that has happened to my friend Major Blake will come before you for judicial investigation. I am anxious to

> attend the Inquest and shall feel obliged if you would let me know when it is held.
>
> Yours Sincerely,
>
> Wm. Beale[127]

Perhaps the most impressive request was a letter received by Gell in 1835 from George von Gersdooft on behalf of a servant in the household.

> The Undersigned Minister Resident of His Majesty the King of Savoy, has the honour to inform the Coroner of Middlesex that considering the circumstances attendant on the unfortunate demise of his late servant, Augustus Endtrick, a native of Savoy, he is willing to waive the privilege, which he as a Minister of a foreign Court, has a right to claim, of being exempted from the jurisdiction of British Courts, and he accordingly offers to attend at the inquest about to be holden on the body of the said Augustus Endtrick, and to give evidence as to the circumstances, connected with that unfortunate affair, which have come to his knowledge: Always, however, under protest, that this confession and his part, be in no wise construed into an abandonment of any of the privileges or immunities, to which he, as a Minister of a foreign Court, is entitled, and be not construed into a judgement on any future occasion.
>
> /Signature and Seal/[128]

The verdict in this case was lunatic suicide and the matter did not need to go to any higher court. However, it is interesting that the coroner had jurisdiction over foreigners who died in England.

One of the most important witnesses was the medical man. When the coroner issued a warrant for medical attendance

at the inquest, he could at the same time issue a warrant for a post mortem examination.

> By virtue of this my Order as Coroner for the City and Liberty of Westminster, you are required to appear before me and the Jury. . . to give evidence touching the cause of death of /the deceased/ and to make or assist in making a post-mortem examination and report thereon at the Said Inquest.[129]

A small series of these documents survived in Westminster Abbey, not with the inquests, but in a separate collection labelled "Surgeons' Accounts."[130]

The parish apparently paid the surgeons' fees. Medical personnel involved with an inquest increased tremendously over the century. In 1760, it was rare to have a medical witness. However, by 1800, one half of the inquests included medical depositions and in 1835 and 1865 it was the rare case that did not include some medical evidence. Similarly, autopsies were rare during the 1760 period, but gradually increased through the century until post mortems were performed in about one half of all inquests.

The jury, after deciding the verdict, established the value of any deodands and ascertained the belongings of any felons. These old perquisites of the Crown had become anachronistic and the jury treated them as such. Deodands through the century were consistently valued at one to two shillings. Objects were obviously undervalued, since a cart, a horse, or a knife would all be assessed as worth two

shillings. Toward the mid-nineteenth century, the jurors started to use the deodand as a fine in cases of obvious negligence. The deodand was valued at fifty pounds in one accident case.[131] However, the deodand was assessed against the owner of the object causing death and did not always correlate with the individual responsible for the accident. Thus, the deodand was a clumsy tool to mete out punishment and did not adapt well to its new role. The deodand was abolished in 1846. Similarly, jurors ignored the old perquisite granting the Crown the felon's lands and chattels. In every existence studied, whether suicide or homicide, the jury found the felon "had no Goods or Chattels, Lands, or Tenements within the said Liberty or elsewhere to the knowledge of the said Jurors." This was true even in a duel of 1765, when William Lord Byron killed William Chaworth Esquire with his sword. This was the case in which eight gentlemen were bound over at sixty pounds to give evidence.[132]

The juries in Westminster took upon themselves new duties in the nineteenth century often appending to their verdicts a request that something be changed. In one instance, the jury requested that "there should be an extra attendant at night of the Metropolitan police from Vauxhall Bridge to the Chelsea Water Works."[133] In another case, a policeman delayed the medical aid for a burn victim, and

the jury requested the Coroner to contact the police authorities. In response, the Metropolitan police wrote that they "have reprimanded their Police Constable for such interference upon the occasion in question."[134] The jury often found reason to complain about the realities of the parish workhouse, an institution whose purposes were to provide work and food for the destitute. In an inquest concerning the death of an eight year-old pauper, many details about the local workhouse became clear.

> Verdict: /The child/ died of a mesenteric disease of a severe nature produced by a scrofulous habit of body.
>
> Deposition of assistant overseer of the workhouse in St. James Parish: Deceased was a pauper-child supported by this parish. His father died in this workhouse. The sum paid for the support of the child was 4s.3d a week by agreement. There was a dietary then approved of by the parish authorities.
>
> Deposition of the surgeon who attended deceased: Deceased had cough and was thin. . . I directed Beef Tea, Mutton broth, sage, Arrowroot, eggs softly boiled, and sometimes sherry.
>
> Deposition of a London Surgeon: The diet stated by /above surgeon/ was proper for a child in that state.
>
> Deposition of another surgeon: I was present at the post mortem. He died of mesenteric disease of considerable time existing--in consequence of scrufulous habit--from the very considerable wasting of the body I am of the opinion that he must have received much attention.
>
> Deposition of Thomas Pettigrew, Surgeon: I was requested by the church warden to see children in the workhouse. . . I met Mr. Brain, parish surgeon in the Board Room and

> asked him as the medical officer of the parish to accompany me--but he declined. The condition of the children was frightfully appalling. They sat on beds with crossed legs emaciation to a greater or lesser degree characterized the whole of the children. The heads of many appeared large, their limbs shrivelled and wasted--the emaciation of some of them was so great that the intricate structure of their joints became apparent. . . all more or less were labouring under severe ailments, that of the stomach and bowels, diarrhea in many cases profuse, considerable discharge of unhealthy secretions which I found in the beds, and also discharge of mucus tinged with blood--feeble and languid circulation and other marks of general debility. . . ulcerations of the skin of the extremities. . .
>
> They complained of Thirst, some were flushed in the cheeks. The skin was uniformly dry. The bones of the legs of three or four took on a curved direction agreeably to the position in which they sat. . . Deceased was one of the worst cases. I told the clergymen of the parish that they all laboured under one and the same disease though varying as to the intensity of the symptoms, and that this disease was that which is commonly described as mesenteric disease, being connected with the digestive or alimentary organs--that the disease was usually connected with a scrofulous disposition of the system and that this was a disease liable to be induced and always aggravated by the administration of improper food.[135]

Scrofulous was a term for disseminated tuberculosis. Mr. Pettigrew was probably correct in guessing that most of the children had tuberculosis, first because of their circumstances and secondly because the disease was so prevalent. The Registrar General statistics for 1838 and 1866 both list consumption as the number one cause of death from

all causes. Rickets can also be construed from the graphically described condition of the children's bodies, in addition to an overall emaciated state. Obviously, the children were not fed adequately. However, according to the testimony, the child in question was fed adequately in the last months.[136] Without such care, he would have died: "from the very considerable wasting of the body I am of opinion that he must have received much attention." After the testimony of nine surgeons, four of whom were present at the post mortem, the sixteen sworn jurors decided the child died a natural death due to disease.

The workhouse was described in another case in 1836,[137] in which a destitute man applied to be admitted into several workhouses and was refused. He had not eaten in three days and was arrested by the police for begging. The man complained of feeling ill and the police took him to the workhouse in a dying state. The jury concluded that the man died of starvation, but were disturbed that he had not been assisted earlier by the workhouse even though he was not a local resident. A press release of the inquest resulted in a small commotion at the Poor Law Commission Office and their secretary wrote the coroner "to state for your information that by law the Overseers of the Poor are still responsible as heretofore for giving relief to persons in a state of destitution." Enclosed also was a copy of the Poor Law Amendment Act stating that "the Overseer is

required to give such temporary relief as each Case shall require in articles of absolute necessity but not in money and whether the Applicant for Relief be settled in the Parish where he shall apply for Relief or not." Furthermore, should the overseer refuse to give relief in these cases "a penalty is specially provided for the refusal, Independently of the former and ordinary remedy of Indictment." The commission wished to have a copy of the depositions to look further into the matter and "should any Master refuse immediate admission of a person in such a state of suffering and destitution as that in which the deceased is described to have been found, the Commissioners would consider it their duty to dismiss such Master from his office."

There were numerous other examples of the juries' involvement with authorities concerning social injustices. However, the coroner generally attempted to limit the official commentary of the jury to the case at hand. In another inquest on a pauper's death,[138] a note from Coroner John Henry Gell to the parish overseer states, "as I was not trying the question as to the treatment of the /other/ children I could not enter into it excepting as it applied to the deceased." This power the jury exercised, based on public censure, was much more effective than the unwieldy deodand. It was apparent in a few notes that survived along with the inquests. In the pauper case just mentioned,[139]

the overseer wrote the coroner requesting that "I hope, in any public accounts the reporters may give of the Inquest, that you will take care to direct, that they forget not to admit our readiness to do all we could to protect our poor children." Several other inquests also were reported in the papers.[140]

The inquests generally lasted hours but on rare occasions could take several days. The coroner hand wrote all official inquests. All depositions were entirely handwritten also by the coroner. Each packet that constituted the records of an inquest contained the official inquest, the depositions, and usually various warrants for the jury, witnesses or medical men. The wording of the inquests varied little from the formulas provided by Umfreville in 1761. Originally, the inquests were handwritten and indented. Presumably, two copies were made and cut apart on an uneven line, with the foreman of the jury receiving one copy and the coroner the other.[141] Forbes[142] noted, however, that between 1830 and 1842, the indented copy of the Westminster inquests reached the London record office, presumably to claim reimbursement of funds. In all but the first period, part of the inquest was a printed form with blanks to fill in pertinent details as below.

> An Inquisition Indented, taken for our Sovereign Lord the King, at the House of Kelsey called or known by the Name or Sign of the Marquess of Anglesey situate in Bow

> Street in the Parish of Saint Paul Covert Garden within the Liberty of the Dean and Chapter of the Collegiate Church of Saint Peter in Westminster, in the County of Middlesex, the First day of January in the Fifth Year of the Reign of our Sovereign Lord William the Fourth by the Grace of God of the United Kingdom of Great Britain and Ireland King, Defender of the Faith; before John Henry Gell, Esquire, Coroner of our said Lord the King, for the said City and Liberty, in View of the Body of Richard Flack then and there lying dead; upon the Oath of the several jurors whose Names are hereunderwritten, and Seals affixed, good and lawful Men of the said Liberty, duly chosen, who being then and there duly sworn and charged to enquire for our said Lord the King, when, how, where, and by what means, the said Richard Flack came to his Death, do upon their Oath say, that the said Richard Flack on the said first day of January in the year aforesaid at the Parish aforesaid in the said Liberty in the County aforesaid departed this Life in a natural way by the visitation of God. In witness whereof, as well the said Coroner as the said jurors, have to this Inquisition set their Hands and Seals the Day, Year, and Place, first above written.[143]

Most of the pertinent information other than the verdict was contained in the depositions. This is why inquests alone or coroner's rolls summarizing the cases are so inadequate.

The inquest was signed by the coroner and the entire jury, except in the 1760 period when only the foreman of the jury signed along with the coroner. Next to each signature was a seal; red wax in 1760, paper seals in 1800, and a facsimile of a seal printed on the inquests in 1835 and 1865. In general, the seal had nondescript, cross-hatching marks or carried the initials of the reigning

monarch. All of the inquests and other documents signed by John Henry Gell, though, carried a seal of a crown with the initials G. R. According to the Westminster Abbey Registers, Gell was granted the arms of the Gells of Hopton, landed gentry in Derby shire, who most likely had no connection to the Westminster Gells.[144]

The depositions themselves appear to be a transcript written verbatim from the oral testimony. Each deposition was signed by the witness, although transcribed by the coroner. Frequently, the witnesses signed their depositions with their "mark," and this was not uncommon even in 1865. On the other hand, throughout the century it was extremely rare for a juror to be illiterate. The depositions ended with the verdict and was signed by the foreman of the jury. In many homicide cases, the depositions were missing. A note in the inquest packet usually explained that the depositions had been sent to Old Bailey for the future prosecution of the accused.

On the back of the inquest, the coroner often annotated his expenses. A form for this purpose appeared in 1865 with spaces to list the fees paid for the constable, the inquest room, the witnesses, the person recovering the body, and the medical witnesses.[145] The constable was paid one shilling for giving information to the coroner (presumably for acquainting him with the possible inquest) and paid six shillings and six pence for summoning the jury and

giving evidence himself. In 1835,[146] the coroner paid five shillings for the inquest room and another five shillings if the body was taken there. For the person who found the body (often the constable), the coroner paid one shilling and four pence, and if the body were retrieved from the water the coroner paid four shillings. Witnesses were paid one shilling per hour and three pence per mile. In one case where two witnesses travelled forty-two miles and stayed one and one half hours, they were each paid twelve shillings.[147] All of these fees were paid by the central government. There is no mention of payment for the jury. A surgeon was paid one guinea for his testimony and another guinea for an autopsy. Apparently, the doctor's fee was paid by the parish, made evident in the following letter written in 1835:

> This Inquisition was fixed for 7 o'clock. After one case, the jury viewed the body of Mr. Lockhart and heard the evidence and on that returned their verdict. At 5 minutes past 7, Mr. Morgan /surgeon/ attended. It being past the time mentioned in his summons and the jury having returned the verdict I stated to Mr. Morgan my opinion that I could not issue the order for the parish to pay the fee-- the Jury then requested me to do so as he had attended within a few minutes of the time etc. and I complied with their request.[148]

The coroner reported his expenses four times a year, at the end of each session; for example, on one inquest was written "winter session accts. sent to Registrar of Rolls."

The accounts were arranged according to the seasons and the coroner was paid according to the number of inquests held and reimbursed by the Registrar for the above mentioned additional expenses. In 1850, each inquest cost the state approximately four pounds.[149]

What is remarkable throughout the Westminster inquests in this century is how little the mechanics of the inquest had changed since its inception in the middle ages. Summoning the jury, viewing the body, and even the wording of the inquest remained essentially the same. The range of circumstances constituting grounds for an inquest was more or less the same as when first defined in the twelfth century. However, the jury now largely ignored the Crown's financial interests, neglecting deodands and the responsibility to assess and confiscate felons' goods. The jury was interested in all the circumstances surrounding the death, and often reflected in their verdict an attempt to reform hazardous social conditions contributing to the death. Furthermore, medicine in the nineteenth century advanced, and with increased interest in post-mortem examinations enhanced the ability of the inquest to determine the true cause of death. Thus, the details of holding an inquest had remained remarkably intact, while the overall emphasis of the coroner and the inquest had evolved from ensuring a source of funds for the Crown to an institution

whose priority was determining the circumstances and cause of death.

VITAL STATISTICS FROM INQUESTS

> The coroners' information, although not made at present on a uniform plan, furnish many valuable facts. . . it is very desirable that. . . the coroner should instruct the juries to state in their verdicts with greater minuteness than at present the cause of death; recording more in detail the nature of the injury, and the circumstances in which the death happened.[150]

The Registrar General in 1842 recognized that valuable information could be collected from coroners' inquests. The coroner was the most reliable source of detailed statistics on what the Registrar referred to as violent deaths: accidents, suicides, homicides, and infanticide. The Registrar did not regularly collect such data itself until the latter half of the nineteenth century.[151] From 1867 on, the Registrar General released national totals for violent death but without a breakdown by districts.[152] Therefore, the information was largely robbed of its potential because comparison of accidental deaths or homicides, etc. could not be made between cities or between a city and the country.

Interest in causes of death in England began sometime in the middle ages. A few clerks from the Fraternity of Saint Nicholas, the guild for parish clerks (dating back to 1232) listed the cause of death as well as the date of death when recording burials in parish registers. Parish registers were first required officially to record burials,

christenings, and marriages in 1538 by Cromwell.[153] Some of these parish burial records have provided data for the study of medieval causes of death.[154] The first major attempt to quantify causes of death, however, was the Bills of Mortality. Reference was made to the Bills in a manuscript of 1532, but the earliest surviving Bill dates from 1582.[155] The Bills were published for general distribution starting in 1594, supposedly because Queen Elizabeth was concerned with the city's growth and hoped the information on deaths would keep people away.[156] The Bills included deaths only for London and nearby parishes, and the data were collected by "searchers," old women paid to knock on the door of every house in the parish and inquire if anyone had died. These women brought their reports to the parish clerks and weekly Bills were published.

> The Searchers hereupon (who are antient Matrons, sworn to their Office) repair to the place, where the dead Corps lies, and by view of the same, and by other enquiries, they examine by what Diseases or Casualty the Corps died. Hereupon they make their Report to the Parish-Clerk, and he every Tuesday night, carries in an Accompt of all the Burials and Christnings, happening that Week, to the Clerk of the Hall. On Wednesday the general Accompt is made up, and Printed, and on Thursday published, and dispersed to the several Families, who will pay four Shilling per Annum for them.[157]

Westminster was added to the Bills in 1626 and the causes of death were ennumerated from 1629 onward. The Bills had many faults and were not always truthful or accurate[158] but at

least the Bills were issued fairly regularly between 1594 and 1850.

John Graunt studied the Bills of Mortality in some detail in 1661,[159] and is often regarded as the father of vital statistics. However, the real growth in interest in causes of death and vital statistics occurred in the nineteenth century with the advent of the Registrar General and eminent statisticians such as Rickmann, Griffith, Brownlee and Farr.[160] In 1800, an Act of Parliament[161] established a national census to be taken every ten years and in 1836, the Births and Deaths Registration Act provided for the collection of certain vital statistics to be published yearly. With accurate information provided by the Registrar General after 1838, population statistics since 1801, and parish burial records as well as the Bills of Mortality, many statistics in the eighteenth century could be estimated.

The tremendous interest in vital statistics for the eighteenth and nineteenth centuries stems from the exponential growth of the English population as the country emerged from the middle ages and approached industrialization and urbanization.[162] The coroners' inquests cannot be a source for many vital statistics because the coroner did not investigate all deaths or even a random sampling. However, the coroner was required to investigate all felonious, sudden, and accidental deaths, and from the inquests in this study

spanning selected periods between 1761 and 1866, some interesting details concerning the vital statistics of death emerge as well as details about the cases investigated. The data will sometimes be discussed as a per cent per million population per annum (hereafter abbreviated pMa). The population of Westminster is known from Registrar General reports for all periods but the first. For the 1761 period, the population of Westminster was estimated as a percentage of the population of London in 1760.[163] The Westminster inquests will be discussed in terms of the number and types of deaths investigated, male versus female deaths, ages at death, illness, prison deaths, and felonious deaths. The types of deaths include illness, accidental, and felonious (homicide, suicide). Accidental deaths, because they yield so much additional information, will be discussed in detail in the subsequent chapter.

The most obvious change over the century studied is the tremendous growth in the number of inquests held per year even adjusted for the increasing population. The relative number of inquests jumped from 46 to 70, to 136, and finally to 160 per 100,000. This represents an increase of 50% between 1761 and 1800, 100% between 1801 and 1835, and 20% between 1835 and 1865. The doubling of inquests in Westminster between 1801 and 1835 is largely reflecting the tripling of accident inquests.

	Total #/yr.++	Inquests	Accidents	Illness	Suicide	*Found Dead	Homicide	Infanticide
1761-5	46	275	114	49	72	18	11	11
male		67%	73%	67%	63%	61%	73%	55%
female		33%	27%	33%	37%	39%	27%	45%
1800-3	70	420	134	164	93	20	4	5
male		68%	69%	70%	70%	60%	25%	40%
female		32%	31%	30%	30%	40%	75%	60%
1835-8	136	1196	536	416	165	62 (9)	9	8
male		71%	72%	68%	77%	63%	89%	60%
female		29%	28%	32%	23%	37%	11%	50%
1865-66	160	796	410	209	73	88 (44)	6	10
male		64%	70%	54%	80%	47%	83%	50%
female		36%	30%	46%	20%	53%	17%	50%

*Found Dead includes found dead and found drowned. The numbers in parentheses refer to infant deaths.

++These are the number of inquests held per 100,000 of the population in one year.

Note: The population estimates for Westminster used in the calculations are:

1760 = 120,000
1800 = 150,000
1835 = 220,000
1865 = 250,000

Distribution of Deaths

Through the century, one third to one half of all inquests were cases of accidental death and another third were cases of illness or natural deaths. The next largest category were suicides, a felony in England during this time, followed by persons "found dead" or "found drowned." Many of these may have been suicides but were usually persons unknown to the coroner or his jury. Although the coroner was considered an integral part of the legal system to discourage felonious deaths, such deaths (homicides and infanticides) comprised a small percentage of the inquests. Homicides and infanticides accounted for ten per cent of cases in 1761 but only two per cent in each of the next three periods.

Male to Female Ratio

In each period overall, men outnumbered women by about two to one, and in most of the subcategories, male deaths also outnumbered female deaths roughly two to one. The one exception was infanticide, where male and female deaths were essentially equal. Farr said in 1838 that "it is well established that the mean duration of life in females is longer than in males. . . the discrepancies may be ascribed to different degrees of exposure to the accidents, hardships, war, and dangers of life."[164] The slight increase in female inquests in 1865 may reflect some degree

	Ages of Deaths*					
	-10	-20	-30	-50	-70	70+
1835	15%	12%	16%	27%	22%	8%
1865	29%	10%	14%	20%	19%	8%

*data only available for the last two periods.

of change in the female lifestyle as they began to work in factories and were exposed to some of the "dangers" as men. The percentage of females in accident inquests did not change, but the percentage of deaths due to illness that involved females increased in 1865-1866.

Age

The ages of the victims in the inquests indicate that the coroner did not investigate a cross-section of all deaths in Westminster. Age was only occasionally mentioned in the early inquests and therefore cannot be studied. However, the age of the deceased was invariably listed in the inquests of 1835 and 1865. According to Graunt's analysis nearly two centuries earlier, approximately one third of all deaths occurred in children under five years of age.[165] In Forbes' studies of parish burial records in the sixteenth and seventeenth centuries, he found up to half of the deaths were children under five.[166] The Registrar General in 1865 determined that twenty-five per cent of Westminster deaths were infants under twelve months, and a full forty per cent were children under ten.[167] Thus, throughout these centuries, mortality of the young remained very high. However, in Westminster, only fifteen per cent of inquests were on children under ten in 1838. In 1865, about thirty per cent of the inquests were on children under ten but ten per cent were newborn infanticides or newborns "found dead." The

coroner did not investigate the illnesses which took the lives of so many of the youngsters in the community. The lowest percentage of inquests were individuals between ten and twenty and the inquests increased with each decade till seventy, running parallel to the age related nadir and rise of deaths in the community. Of interest, though not surprising, is the fact that there were no suicides under the age of ten.

Illness

Graunt noted in his study of the Bills of Mortality that "Autumn is the most unhealthful."[168] Farr noted in 1838 that deaths were highest in the winter but that this was much less significant than the variation of death with seasons during plague years.[169]

Deaths per 100 living for Winter/Spring/Summer/Fall

1838	.85/.10/.60/.66
1606-1610	1.7/2.0/16.3/5.0

Overall, the inquests did not vary significantly with the seasons, but deaths from illness were more frequent in the winter. Illness constituted about a third of all the inquests. However, the coroner did not investigate illness routinely. There had to be special circumstances surrounding each case which prompted the coroner to investigate. These circumstances by definition were those in which death was thought sudden, unexplained, accidental, or felonious.

ILLNESS BY SEASON

January-March	April-June	July-September	October-December
31%	26%	18%	29%

TYPES OF ILLNESSES

	VOG*	Spec. Dis.**	Apop-lexy	Still Birth	Consump-tion	Fever	Heart Dis.	Typhus	Want
1761-5	67%	33%	4	4	1	5	0	0	2
1800-3	80%	20%	18	8	1	3	0	0	3
1835-8	67%	33%	76	14	11	6	15	5	6
1865-6	61%	39%	17	5	33	1	21	1	2

*VOG is an abbreviation for death by the "visitation of God."
**Specified Diseases.

BILLS OF MORTALITY

	Convul-sions	Consump-tion	Fever	Small Pox	Aged	Dropsy	Teeth	Still Birth
*1630-60	9073	44487	28784	10576	15757	9623	14236	8559
*1762-77	89221	68949	48594	36276	22032	14038	11918	10241
*1754-62	53499	27051	20583	16932	12711	6875	6538	--

*The figures come from Graunt, Black, and Short, respectively.

This is reflected in the spectrum of illness the coroner reported, which differed from the spectrum in the general population. Graunt, from the Bills of Mortality, discovered in the century before that the major killers were consumption, fevers, age, chrisoms (christenings), and teething. The latter two categories refer more to the time of death than the cause, but it was a common misconception that teething caused death.[170] The Bills around 1760 indicated that large numbers of deaths were due to convulsions (children), consumption, fevers, smallpox, age, dropsy, and teeth.[171] A century later, in 1865, the Registrar General still found consumption and fevers the leading causes of death.[172] The coroner, on the other hand, found apoplexy the most common illness specified in the inquests. Apoplexy used to be known by the contemporary appelation "sudden." Heart disease could also result in a sudden death and was mentioned fairly frequently in the inquests. Other diseases of interest for public health reasons such as smallpox were largely ignored by the coroner. There was only one inquest of smallpox in 1838 while 469 deaths were due to smallpox that year in Westminster.[173]

The most common verdict in cases of illness was "natural death by the visitation of God." This verdict served for two thirds of the deaths from illness. Forbes found in his study of Middlesex inquests during the early

nineteenth century that this formula "visitation by God" was used in eighty per cent of the illness deaths, and that coroner even had formal inquests printed up with this verdict so only the name and date needed insertion.[174] The Registrar General complained that "such verdicts as natural death or visitation of God, it is scarcely necessary to say, are no answers at all, but mere evasions of inquiry."[175] Although not commendable, once the coroner's jury was satisfied that a death was neither accidental nor felonious, they were entirely satisfied.[176]

Prisons

The coroner always investigated deaths that occurred in prison. Umfreville wrote in 1761,

> if a man die in prison, the coroner is to take an Inquest on view of the body and if it be found that the Prisoner was brought nearer to Death. . . the law will imply Malice for a prisoner is safely to be kept, but not punished, in Gaol.[177]

Nearly all the prison deaths in this study were ascribed to illness that developed while the prisoner was incarcerated. McCulloch noted[178] "prisoners rarely labour under any serious disease at the time of their committal." Between 1826 and 1831, the average committal was forty-eight days and the mortality in prisons was sixty per cent higher than for the rest of the country.[179]

PRISON DEATHS

	VOG	Specified Diseases	Consumption	Fever	Dropsy	Typhus	Bowel	Misc.*	Suicide
1761-5	71%	29%	0	2	0	0	0	0	1
1800-3	75%	25%	0	3	0	0	0	0	1
1835-8	16%	84%	8	6	3	5	5	20	1
1865-6	6%	94%	24	2	2	1	2	20	4

*Miscellaneous includes pneumonia, asthma, hernia, apoplexy, erysipelas, delirium tremens, heart disease, rheumatic fever, hemorrhage, hydrophobia, brain tumor.

Note: The prisons in the various periods were:

1761-5	Westminster Bridewell	6 prisoners
	Gatehouse	2 prisoners
1800-3	Westminster Bridewell	9 prisoners
	Tothill Fields	4 prisoners
1835-8	New Bridewell	24 prisoners
	Millbank Prison	23 prisoners
1865-6	Millbank Prison	27 prisoners
	Tothill Fields	31 prisoners

Prison deaths form a subsection of the total deaths from illness. Prison inquests are a select group in which ninety per cent indicated a specific type of illness. This contrasts with the Middlesex inquests from 1819 to 1842 in which nearly all prison deaths were recorded as "natural deaths by the visitation of God."[180] The spectrum of disease recorded reflected the prevalence of the individual diseases in the community already mentioned--consumption, fever, and dropsy. The six cases of typhus recorded under illness were all prisoners. Typhus was sometimes believed to be endemic to prison life although it also was prevalent in the community, 421 cases occurred in Westminster in 1865-1866.[181] In the Westminster inquests, prisoners accounted for nearly a half of all the inquests ascribed to a specific illness and a fifth of all illness verdicts.

Felonious Deaths

Of the felonious deaths that occurred in Westminster, homicide and infanticide demonstrated no obvious trends. Hair cites the incidence of homicide as 74 pMa in 1700-1750 based on the Bills, and 20 pMa in 1860 based on Registrar General data.[182] Homicides may have been decreasing in Westminster between 1761 and 1866 but not dramatically. Infanticide also did not reflect any dramatic trend. However, verdicts of accidental suffocation markedly increased

	Homicide	pMa	Infanticide	pMa	(Acc. suff. pMa)
1761-5	11	18	11	18	(3)
1800-3	4	7	5	17	(3)
1835-8	9	10	8	9	(19)
1865-6	6	12	10	20	(94)

	Suicide	pMa	Found Dead*	pMa
1761-5	72	120	18	30
1800-3	93	155	20	33
1835-8	165	188	53	60
1865-6	73	146	44	80

* Found Dead here considers only adults who were found dead or drowned.

and this may have represented undetected infanticide or a lenient attitude on the part of a sympathetic jury.

Suicide revealed some very interesting data. It appears to have markedly increased in Westminster from 120 pMa in 1761-1765 to 155 pMa in 1800-1803, 188 pMa in 1835-1838 to 146 pMa in 1865-1866. Furthermore, "found dead" and "found drowned" victims, probably often suicide cases according to Hair,[183] markedly increased from 30 pMa to 33 pMa, to 60 pMa to 88 pMa. These together with the known suicides, each period exhibits a higher frequency of suicide than the preceding period. This could reflect the increased tensions of industrialization in Westminster and the devaluation of life in the period. Alternatively, the rising suicide rate might be due to a higher degree of reporting of suicides to the coroner. There is no doubt that the coroner's investigations had advanced, benefitting from the addition of medical expertise and the improved police investigative skills.[184]

Thus, the Westminster inquests are a source of unique information reflecting many of the consequences of the rapid upheaval experienced in the first half of the nineteenth century. Accicental deaths increased four times, corrected for population, through the study and almost tripled in only thirty years, 1800-1835. Documenting and analyzing the

details of this tremendous growth in accidental deaths will be the subject of the next chapter. Illnesses also peaked in the first half of the nineteenth century, possibly reflecting the squalor of the rapidly growing city. Homicide slightly decreased over the course of the study, infanticide may have increased, and the suicide rate peaked around 1840. This period, around 1840, emerges as one of rapid industrialization and tumult. While vital statistics were collected by various sources with varying quality, these provide simple numerical totals only. However, the inquests supply numerical totals in subcategories not found in other sources; but even more important, the depositions provide the sole source of detailed evidence on a wide range of social, medical, and legal issues. This will be outlined for accidental deaths in detail in the next chapter.

ACCIDENTAL DEATHS

According to data released by the Registrar General, violent deaths comprised three per cent of all deaths in England in 1838 and four per cent in 1856.[185] Violent deaths include falls, burns, drownings, casualties, poisonings, suicides and homicide. Though small in number relative to the total number of deaths, it is with these that the coroner was intimately involved. These deaths were important because they were costly and largely preventable. Dr. Farr wrote in his letter to the Registrar General in 1838:

> The violent deaths are exceedingly numerous--drownings, fires, accidents with machinery, etc. . . In a political point of view, violent deaths are of great importance, as they bear more upon the efficient part of the population.[186]

Since the middle ages, the coroner had investigated accidental deaths, which were ninety per cent of all the violent deaths and nearly one half of all inquests. The coroner was always to investigate all misadventures[187] and a 1510 statute reiterated that the coroner must investigate under penalty of fine "if any person hath happened to be slain by misadventure and not by no man's hand."[188] In practice, one third to one half of the inquests held in Westminster ended with a verdict of accidental death.

These inquests and depositions reveal a great deal of particulars concerning each accidental death. Until 1846, this included the assessment of the deodand. Normally, this was valued at one to five shillings, usually far less than its true worth. However, the jury occasionally assessed the deodand's worth accurately to express their displeasure with unnecessary negligence. Negligence was frequently obvious in traffic accidents.

> The deceased told me that a cab had driven against him and set the Horse prancing and then the Horse threw him and it was that that injured his collar Bone and Ribs--I could not ascertain what cab it was--the deceased said it went immediately--He several times said it was entirely owing to the misconduct of the cab or the driver of it. No one of the neighbors could give me any account of the cab--excepting that the driver went away quite fast.189

The jury assessed the horse of the deceased as a deodand worth one shilling. They also assessed as a ten pound deodand the cab and horse causing the accident ruling it was "moving to the death of" the victim. Such use of the deodand as an instrument of social reform occurred almost solely in the 1835-1838 period of this study and is in concert with the growing social awareness of the period. A similar incident in 1837 resulted in an even larger fine.

> I saw a Gentleman's carriage drawn by 2 Horses come from the Quadrant way right across the Circus. The Horses were trotting pretty fast--at the rate of 8 or 10 miles an hour, rather faster I think than usual. The Horses went straight on--the Horse on the near side

> went against the deceased and knocked him down. I do not know what part of the Horse struck him. A woman near screamed for the coachman to stop, he did not stop. There was one gentleman in the carriage. There was a Footman behind it. I did not hear the Coachman call out at the time. The Coach went below Jermyn Street when a policeman stopped him.190

In this case, the jury assessed two deodands, the horses owned by a stablekeeper at five shillings, and the carriage believed to belong to the gentleman riding in it, at fifty pounds. Unfortunately, the carriage had been rented, and a note from the constable to the coroner indicated that the deodand was collected from the true owner, who was not involved with the accident.[191] In similar cases, the jury usually declared only the one horse immediately causing the accident as the deodand. The jury exercised great flexibility defining their worth. In another case of the same period and actually more representative,

> /the deceased/ being employed to lay down some Water Pipes for the Chelsea Water Works Company: It so happened that accidentally, casually, and by misfortune the air Boxes connected with the said Pipe suddenly together with the said Pipes sank and by means whereof threw /the deceased/ in the Water of the River and the said Pipes and Air Boxes were the Cause of Death and are of the Value of one Farthing and the Property and in the Possession of the said Chelsea Water Works Company.192

This was not considered to be a case of negligence, but one of the routine risks inevitable and accepted in the work

conditions of the period. Wellington reports an inquest resulting in a verdict of wilful murder in 1840 and a deodand of two thousand pounds assessed against the London and Birmingham Railway Company.[193] Such cases, which could involve very expensive machinery, quickly led to the demise of the deodand, and it was abolished in 1846.[194]

In Westminster, 1,194 inquests (of a total 2687) were due to accidents over the four periods from 1761-1866. Accidents grew at a faster rate than the overall total number of inquests, increasing fourfold while the total number of inquests tripled (both corrected for population).[195] This could indicate either that the coroner was simply seeing more inquests per 100,000 population, and proportionately more accidents, or that accidental deaths in the population had become a larger percentage of the total deaths as the century progressed. Indeed, Walford extracts from the Registrar General reports overall numbers of violent death for all of England that support the latter theory. He cites the incidence of violent death (over 90% of which were accidental deaths) increasing from 600 pMa in 1838 to 800 pMa in 1856 and 830 pMa in 1865.[196] Hair notes from his study of Shropshire, an increase in accidental deaths from 400 pMa in 1780-1784 to 630 pMa in 1805-1809. These figures for England correlate extremely well with those for Westminster and indicate the coroner saw nearly all the accidental deaths. The inquests could produce a lower rate than the national average

	Accidents	male/female		ratio (m/f)	pMa
1761-5	114	83	31	2.7	190
1800-3	134	92	42	2.2	223
1835-8	536	385	151	2.6	609
1865-6	410	286	124	2.3	820

	A-general	A-traffic	A-drowning	A-fire	A-suffocation
1761-5	51%	22%	16%	10%	1%
male	78%	80%	72%	27%	50%
female	22%	20%	28%	73%	50%
1800-3	43%	24%	13%	19%	1%
male	79%	72%	100%	20%	50%
female	21%	28%	0%	80%	50%
1835-8	36%	24%	13%	24%	3%
male	83%	83%	91%	36%	53%
female	17%	17%	9%	64%	47%
1865-6	49%	17%	3%	20%	11%
male	82%	81%	100%	42%	43%
female	18%	19%	0%	58%	57%

due to either a truly lower incidence in Westminster or due to fault of the coroner not seeing all cases. However, the inquests cannot produce figures higher than the national average unless the rate in Westminster were truly higher. Thus, if the inquest rate produces statistics that are comparable to data from the Registrar General, the coroner probably saw nearly all cases. The growth rate for accidents alone accounted for two thirds of the increased inquests (per 100,000 people) seen in the century.

Distribution of Accidental Deaths

Accidental deaths in Westminster were, as expected, predominantly male, approximately two and a half times more frequent than female deaths. Of interest is the fact that the coroner saw an increasing number of female accident victims and the ratio of men to women did not increase. Men worked outdoors more and were more prone to the falls from scaffolds, traffic accidents, and machinery mishaps which became increasingly more common through the century. Furthermore, accidents from general causes such as falls remained mostly male, and alone accounted for half of all accidental deaths in 1865. The reason female accidental deaths maintained a constant percentage of the accidental deaths was due to two facts; the percentage of deaths due to fire, predominantly female, rose through the century while drowning accidents, mostly male, declined significantly.

SEASONAL ACCIDENTAL DEATHS

	J-F	M-A	M-J	J-A	S-O	N-D
Male deaths	15%	20%	18%	18%	17%	12%
Female deaths	21%	16%	16%	10%	17%	20%

ACCIDENTS BY AGE*

	-10	-19	-20	-39	-59	-79+
Male deaths	22%	19%	18%	15%	15%	11%
Female deaths	48%	9%	7%	6%	10%	20%

*These are based only on the two last periods when the data on age were consistently available.

Most accidental male deaths occurred during the summer while working outdoors and most accidental female deaths occurred during the winter while stoking the fire. This is shown in the chart listing the number of accidental deaths by month. In the later two periods, when the ages of the accident victims were consistently available, analysis of the ages also supports this general theory about lifestyles. Of the men who died in accidents, forty per cent died in their prime, their second or third decades. Among the women, twenty per cent were over seventy and a full fifty per cent were under ten. It was the old and the young who most frequently died from catching fire.

General Accidents

The most common cause of accidental death was classified as general accidents, mostly falls or injuries from falling objects. These were numerous, generally involved males, and were usually occupational deaths which will be discussed in detail later. The others, various domestic accidents, included falls from windows or down stairs. For example, Elizabeth Oakham was walking along a footpath at night, and the lighting was so poor that she fell into a cellar which extended onto the footpath.[197] The coroner wrote the following memorandum when he "viewed the body" at the site.

> Memorandum: Asked here this morning and made the following observations which appeared so important that I have put them down. That the opening to the Coal Cellar where the poor woman Oakham lost her life projects 15 inches onto the pavement--and the Cellar was protected only by a very slender Railing and the Gate of the Railing fastened by a small piece of string--the Railing is of so slight a nature that any person pressing upon it of moderate weight would necessarily break it down--and have also been informed by a respectable neighbour that this is not the first accident that has occurred at the same place. It is submitted under the above Circumstances whether 2 of the Jury should not be deputed to examine the premises.198

Submitted at the inquest was a drawing of the premises. Domestic accidents could also be on a grander scale, such as the collapse of the floor of a schoolroom. The room was crowded and sixty people were injured. A blueprint of the school was submitted to the coroner's jury, and testimony suggested that one of the beams supporting the floor was defective. The jury concluded, "the death of the deceased was occasioned by the falling of the floor and the Jury are of opinion that a defective beam was inadvertently used in the building but that such defect was not apparent at the time of its erection."[199] As indicated by the large number of general accidents, people in this century were constantly falling down, from, or through something or being exposed to the dangers of objects falling upon them. General accidents increased fourfold through the century, from 97 deaths pMa to 402 pMa.

GENERAL ACCIDENTS

	A-gen	pMa
1761-5	58	97
1800-3	58	97
1835-8	191	217
1865-6	201	402

Traffic Accidents

The second most common type of accidental death through the century were traffic accidents, where a pedestrian, a rider on a horse, a passenger in a coach or a driver might meet his untimely end. There were many types of vehicles including cart, wagon, dray, van, cab, tramcar, omnibus and coach. Hair estimates that in the period between 1700-1900 there were at least five to ten horses per 100 persons.[200] Coaches alone increased from 100,000 in 1834 to 450,000 in 1874 and these were always far outnumbered by carts and wagons.[201] In each period, traffic related accidents accounted for about a quarter of the total accidents, and this generally agrees with the Gentleman's Magazine estimate in 1806 that twenty per cent of all accidents were due to traffic.[202] In Westminster, 80% of traffic deaths were males, and this can be accounted for by the greater exposure outside the home and the many that were occupation related. Traffic accidental deaths increased more than three times independent of population growth, rising from 42 pMa to about 140 pMa. These figures are markedly above the national average. The Registrar General data give a national incidence of 60 pMa in 1840 and 55 pMa in 1874 (both 85 per cent male deaths).[203] However, Westminster was a highly urban environment, crowded with traffic, and the national statistics are averaged over the entire population, much of which was still rural. In

TRAFFIC ACCIDENTS

	A-traffic	pMa
1761-5	25	42
1800-3	32	53
1835-8	130	148
1865-6	69	138

one incident, a man was killed when an omnibus drove under a low arch and he was knocked off.[204] In another inquest, the deponent describes a common occurrence.

> There was a cart coming along and it ran foul of my Gig--it was trying to pass us and touched my outside wheel and lifted the wheel I suppose 12 or 14 inches and the deceased fell out.[205]

The city of Westminster thus had a much higher incidence of traffic deaths than the national average, and if the coroner had not seen all the victims, the incidence would be higher still. The experience in Westminster was probably representative of most medium to large size cities. One fact that seems clear from the Westminister data is that traffic accidents rose through the century, although they may have started to level off about 1850. The national average fell to 44 pMa by 1903 (from 55 pMa in 1874).[206]

Drowning

In the 1761-1765 period, the next most frequent cause of accidental death was drowning accidents. They occurred in the Thames, Serpentine River, Grosvenor Canal, and occasionally in wells or reservoirs. Usually the victims were working on the Thames, bathing, or ice skating. Almost all were males.

There also were occasional boat tragedies. In 1866, four people lost their lives when sleeping on a barge loaded with gravel that sank overnight. The Inspector of the Thames Police described the incident.

> The Barge was lying head down the River, her stern up and her anchor down she was partly laden with gravel. I saw no rope fastening her. I believe the rudder had no command of the Barge and that on the flowing tide she got her head under the timber of the Thames Embankment. This state of things has been in existence about 3 months. It did not occur to me that there was any danger in it.207

The jury's verdict stated, "the four persons lost their lives by drowning by the sinking of the Ann Barge and we accompany our verdict with a recommendation to Mr. Furman the Constable of the Thames Embankment to maintain the water above the embankment and not repeat lamentable accidents."

In medieval times, drowning was so common an occurrence that Bracton titled his section dealing with accidental deaths "De Submersis," or concerning drowning.[208] Hair claims that for all of England the national annual mortality from drowning between 1650-1900 was not below 100 pMa[209] and Gentleman's Magazine estimated that in 1806 drowning accounted for 20% of accidental deaths in England.[210] Westminster was far below this average with a drowning incidence of about 25 pMa, and drownings fell from sixteen to three per cent of all the accidental deaths in the century studied. The 1835 Westminster figures alone are high for drownings, but there were two multiple drowning tragedies. On December 26, 1835, seven died skating on the Serpentine River when the ice broke and the same year three died ice skating on the Grosvenor Canal. This period also had a large number of bathing

accidents, maybe because the summers were particularly warm. When corrected for its 18 skaters, instead of the usual two, and 21 bathers, instead of the usual seven to ten, the period produces an incidence of drownings of 37 pMa, which were six per cent of the accidents reported to the coroner that year.

Usually, the high incidence of drowning in eighteenth and nineteenth century England is attributed to the reliance on the Thames for employment and travel as well as its immediacy. The fact that extremely few Englishmen could swim was markedly apparent in the inquests. Often, several people were "bathing" and could only watch the victim who had lost his footing, drown.[211] Why the Westminster incidence was so much lower than the national average, as demonstrated in the chart, is puzzling. Forbes suggested this was due to a relative lack of waterfront property compared to other parts of Londond.[212] However, according to the Registrar General report in 1861, much of Westminster's population bordered on the Thames, excluding only two parishes, St. James Westminster and St. George Hanover Square.[213] Thus, lack of waterfront property cannot fully explain the low number of drownings in Westminster. Also, given the compulsion and detail of the Westminster coroners throughout the century, it seems unlikely, though possible, that they saw only a third to a half of the accidental drownings.

The Registrar General report for 1850 indicates a national incidence for drowning of 120 pMa but not until 1920

ACCIDENTAL DROWNINGS

	A-drowning	pMa	Total Acc. %	Male/Female %	%	Found Drowned (pMa)
1761-5	18	30	16	72	28	(18)
1800-3	17	28	13	100	0	(32)
1835-8	72	80 (37*)	13 (6*)	91	9	(44)
1865-6	12	24	3	100	0	(44)

*These figures in parenthesis are corrected for several water tragedies discussed in text.

THAMES RIVER-FRONT PROPERTY*

Districts of Westminster	Area (acres)	Land Bordering River (acres)
St. John the Evangelist	210	50
St. Margaret	629	28
St. Martin-in-the-Fields	241	22
St. Paul Covent Garden	6	5
St. Mary le Strand	13	9
St. Clement Danes	20	16

*Data comes from Registrar General as indicated in text.

did the Registrar General differentiate between accident and "found drowned," which as mentioned before was often an euphemism for suicide.[214] The coroners of Westminster, however, did separate the found drowned from the proven accidentally drowned and this distinction was maintained in this study. Even after combining accidentally drowned with found drowned, Westminster was still signoficantly less than the national average. Often the inquest would mention whether the victim's wallet was missing and the jury also attempted to discover whether the deceased had recently been "melancholy." Of the 49 bathing accidents, 47 occurred between June and September and all were male. On the other hand, of the 90 victims found drowned, the deaths were an evenly distributed eight per cent per month, and 31 per cent were females. By contrast, females were only three per cent of all proven accidental drownings. The proven suicides of the century were 73% male and 27% female. It seems likely that most of the found drowned victims were hidden suicides and that the true incidence of accidental drowning in Westminster was in the range of 30 to 50 pMa. The incidence when found drowned victims are included is about 60 to 70 pMa. Obviously, this rate can fluctuate greatly due to the variability of suicides and the possibility of tragedies involving several lives on the water. However, it can be confidently said that the proven accidentally drowned

SUICIDE AND POSSIBLE SUICIDE

	Suicide	pMa	Found Drowned	pMa
Male	73%		69%	
Female	27%		31%	
1761-5	72	120	11	18
1800-3	93	156	19	32
1835-8	165	198	39	44
1865-6	73	145	21	44

averaged about 30 pMa in Westminster and slowly fell through the century.

Fires

Accidents due to fires could claim single or multiple victims. Occasionally, an entire house would burn down trapping the occupants. In 1764, six persons died in a fire.[215] A fireman in 1837 describes another scene.

> We were called to attend a Fire. I attended immediately with an Engine. The Engine I first took was a hand one--we do not take the Ladders with that Engine. . . I saw a woman at the second floor window and we began raising our Ladders but she disappeared before we could get up sufficiently high. . . The Fire Escape was brought after our Ladders. . . 10 or 12 people tried to use the Fire Escape--They tried for 10 minutes but could not raise the Fire Escape--we are used to the Ladders.
>
> About 7 o'clock I saw the dead body of the Man and young woman in the second floor front Room--the dead child was with the young woman grasped in her arms.216

Occasionally, there was an unusual accident such as a thirteen year old boy who had "a quantity of Rockets, crackers, and other Fireworks /which/ accidentally casually and by misfortune took light."[217] However, the vast majority of fire accidents involved young children who, dressed in pinafores or petticoats and standing near the fire, were frequently burnt. Equal numbers of young boys and girls died in this way, because they were dressed the same until

FIRE ACCIDENTS

	A-fire	pMa
1761-5	11	18
1800-3	25	41
1835-8	128	145
1865-6	81	162

the age of around two, and then the mortality rate for boys dropped sharply, while that for girls tapered more slowly.[218] In the data from the Westminster inquests, 60% of all accidents with fire occurred under the age of five; 45% were boys and 55% girls. The other group at risk were the old women, careless or uncertain about the fire. In these inquests, women over age 70 accounted for 10% of the fire victims. Burn victims were usually brought to the hospitals. Often oil was poured over the burn, then it was dredged in flour, and usually poulticed.[219] Without antibiotics and venous access to regulate fluids, regardless of treatment, few could survive.

Through the century, fires claimed proportionately more lives. Deaths corrected for population showed a nine-fold increase, from 18 pMa to 163 pMa. Forbes noted a seven-fold increase in inquests of fires while the population doubled between 1788 and 1829 in London.[220] The Registrar General also documented a rise from 120 pMa in 1850 to 150 pMa in 1864 nationwide.[221] This was thought to be largely due to the movement from countryside to city causing increased crowding and also because women and older children were employed in factories leaving the young and the old at home alone.

Accidental Suffocation

Another product of the Victorian age was the awareness and prevalence of infanticide. Among the Westminster inquests is a tremendous increase in infants suffocated (see chart). In the 1760 period, only two persons suffocated, both adults. In the other periods, all but five were children; in 1800 and 1835, a total of three adults died of charcoal fumes and were given the verdict "suffocation." The rest were infants with approximately equal numbers of males and females. Occasionally, an infant could have been suffocated by numerous bodies in one bed which was frequent in the nineteenth century. But such an increase seems ridiculous and it is felt by many authors that this was a form of infanticide increasing in the century.[222] However, it seems unlikely that the coroner suddenly became more concerned with possible infanticides in the nineteenth century when the law was much stricter earlier.[223] Brend suggests the theory that suffocation was only a simple explanation advanced by physicians and coroners' juries for deaths from several subtle illnesses that became more common as crowding increased. He states that rooms were crowded in peasant country villages also, yet there is a tremendous discrepancy between numbers overlaid in rural and urban environments. He also documents very low rates of suffocation deaths for Westminster between the years 1907-1911 when autopsies were ordered by the coroner

in 96% of cases.[224] Most of these infants died from a variety of natural causes. He notes "even in broncho-pneumonia, the patches of consolidation in the lungs, if not well marked, may be overlooked by a general practitioner and the parents may have. . . regarded the symptoms as trivial or due to a cold."[225] Whether those suffocated in this Westminster study were infanticides or died from subtle overlooked common illnesses bred in the squalor of the new cities cannot be determined, but these deaths certainly were investigated more frequently through the century.

Occupational Deaths

The inquests also shed light upon occupational deaths. Very little information has been collected on occupational hazards. Hair found, when studying British coal mines, that the only information available prior to 1850, other than few and inadequate news reports, was present in great detail in coroners' inquests.[226] His study of coroners' rolls in Shropshire greatly added to the understanding of coal mine related accidents. With the advent of the Registrar General, national statistics began to appear and to detail the hazards of the coal mining and railroad industries. However, statistics went no further than this and the railroad data did not discriminate between employees, passengers, and pedestrians.[227] In 1775, Percival Pott described scrotal cancer in chimney sweeps and half a century later Thackrah,

a Leeds' physician, published his work on occupational diseases.[228]

In 1865, the coroner held an inquest on a man who died "from epileptic fits caused by the inhalation of noxious Gases arising from the preparation of White Lead while employed at Mr. Freeman's White Lead Works."[229] A fellow laborer testified that the deceased "had complained of his insides and giddiness--I have suffered in the same way and I find other men also suffer." The hospital physician performed an autopsy and testified "I found distinctly the blue line at the junction of the gums with the teeth. . . I found a thickening and inflammation of the intestines. . . he died of Epileptic fits caused by lead poisoning--Epilepsy is a usual consequence." The death was classified as due to illness. It was not until the end of the nineteenth century that lead work employees were given periodic medical examinations to ensure some reasonable standards of safety in their work.[230]

All the occupational deaths in Westminster except those of three female servants were male and the greatest number occurred in the construction industry. Throughout the century, inquests re-emphasize the frequency with which men fell from scaffolds: painters, brick layers, carpenters, and unskilled laborers. Walford commented "violent deaths of men were very generally from the effects of falls"[231] and as mentioned, falls accounted for a very large proportion

MALE OCCUPATIONAL DEATHS

	Labor	Thames	Construction	Traffic	Brewer	Misc.*	Machine	Railroad
1761-5	4	3	14	13	1	2	--	--
1800-3	4	5	11	9	--	2	--	--
1835-8	25	8	54	38	--	2	6	10
1865-6	29	8	31	21	2	4	16	17

*includes: chimney sweeper, baker, farmer, sawyer, printer, chemist.

of accidents. Construction workers were also in danger when taking down an old house. In one remarkable case, there were 28 depositions and a special report solicited by the jury from a consultant surveyor. The inquest lasted three days. Several deponents described the incident.

> It was a mere moment from the time I heard the cracking to when the houses fell the wall seemed to bulge out about the middle and come across the road. . . I saw the 2 houses falling out--I saw men's faces in both houses. . . I ran over there was a thick cloud of dust--we heard a man hallowing--we could see his head and part of his body. We removed a large arch of brickwork weighing about three hundredweight--We went further and we found 2 men lying one on top of the other--I found the deceased and he was already dead.[232]

The inquest was apparently so thorough because "there was no boarding outside and no mention of danger." The surveyor called in as an expert witness concluded that there was "so little appearance of danger. . . that it was a matter of consideration with the owner whether it would be prudent to repair only or to rebuild." The buildings "upward of two hundred years old" were thought to be in tolerably good shape and the weaker house, when it fell pulled the other down because of a shared or "party" wall. All injured in the accident were construction workers and given the "tolerable" surroundings of their work, it is understandable why so many died.

Many others were killed due to poor working conditions such as insufficient light and long hours,[233] but the

outstanding story of the century was the growing number of machine related deaths. There were no machine related deaths in either of the two earliest periods but by 1835 it was no longer rare. Simple machines such as a chaff machine had "a wheel to draw the Hay up to the Knives" and somehow engaged the deceased's hand which ended in lock-jaw.[234] Laborers dealing with various pulley systems to lift heavy loads frequently led to occupational deaths, and occasionally produced elaborate diagrams submitted to the jury to explain the leverage and the weight of the loads involved in the accidents.[235] Precautions were rarely evident in any working situation and back-up systems were generally non-existent. In a paper manufactory, pulp was boiled in large vats called coppers. In an 1865 case, "steam was issuing from the Copper which caused the explosion and the deceased and the lid of the Copper were thrown in the air."[236]

The development and embracement of steam in the nineteenth century marked the era and accounted for an increasing number of deaths. In an interesting combination of old and new, a windlass and steam engine were used together.

> We were at work packing the Steam Engine. . . The steam was not powerful enough and so the Rope on a windlass was used to gain more power--it is usual to use the Rope on such occasions.[237]

However, the steam was not "properly fastened off and the said steam engine forced up the piston thereof and suddenly

turned the handle of a crab (a variant on a windlass) and the handle struck the deceased. . . The jurors strongly recommend that some competent engineer should superintend any future repairs or packing of such steam engines." An interesting note is that this powerful new machine had 70 horsepower and belonged to the Chelsea Water Works Company which owned six such engines and employed one engineer and six engine drivers. In an early railway accident in 1835, the jury found cause again to instruct the employers to pay more attention to the safety of their employees. "The Jurors would call to the attention of the London and Birmingham Railway Company[238] the dangerous situation of the Breaksman when on the 'soul' of the wagon, by their providing more safe means for his disengaging the Rope that connects the Engine with the train of Waggons." This verdict was inspired by the testimony of the engine driver.

> The deceased was what we call a Breaksman--an assistant who rides upon the waggons to put down a break when necessary and to help in taking off the Rope. . . there is a temporary Railroad for the purpose of conveying the materials--about 20 empty waggons were in a train and these were drawn by a Rope about 14 yards long which was attached to a Steam Engine on the main Railroad--the temporary Railroad being parallel thereto and about a yard apart. The Rope we then used was several yards longer than one we had before used. The deceased was in the first waggon they were going at the rate of about 13 miles an hour--as we came to a certain place the first waggon jumped off the temporary Railroad toward the main Railroad and by the shake it threw the deceased to the ground. . . he had fallen between the Rails--I saw that one of the waggons passed over him and it dragged

> him 2 or 3 yards--I stopped the Engine as soon as possible. It ran 30 or 40 yards--the first waggon broke away and one or more injured him . . . each of them weigh I consider about 30 cwt (3,360 lbs.)--he was riding on the soul a part of the front of the waggon.239

Variations on steam engine deaths were seen in many areas; loading a barge with a steam engine,[240] working on a steam boat,[241] a circular saw mill "moved by the powers of a Steam Engine,"[242] a distillery whose machinery was powered by steam "to pass grains down a passage to a mash bin,"[243] and a steam printing machine.[244] Steam was employed in nearly every conceivable way after 1835. The accidents by and large were due to unprotected machine parts capturing clothing and pulling in the victim. There were no safety features. The situation is well illustrated by the case in the circular saw mill.

> The saw mills are worked by steam I believe of 5 Horsepower. The deceased was wearing the Frock of a sawyer and it was too long for him. . . I heard a noise like someone exclaiming 'oh' but not loud--I saw the deceased who was wound to the shaft--the wheels at that time going at full speed (the shaft is horizontal 2 inches square and I suppose goes around about 80 times a minute). I ran to the Engineer for him to stop the engine there was a great deal of noise with the Machinery and I had to go 5 yards to make him hear--he stopped the Engine as soon as he could.245

One other new invention, the "lift," caused several deaths in these inquests. The earliest ones were "worked by a rope by the hand" and could ascend "quite 40 feet." In one case, the lift was used in a warehouse to speed

labor transporting materials among five floors. A life was lost because the lift "jumped and sprang up and the deceased fell down the shaft."[246] One of the first domestic lifts installed was at the Grosvenor Hotel to transport luggage and porters. This was a special hydraulic lift "started by pulling a rope and opening the valve which supplies the force of water." The complexities of the machine forced the coroner to request a special report from a civil engineer for an explanation of its workings to ascertain the cause of the accident. The jury learned these particulars in minute detail from the special report.

> Report on an accident which happened on the 12th June 1865 through the failure of the Hoist at the Grosvenor Hotel Pimlico.
>
> The hoist in question is a small movable cage or room, about 7 feet square, made with wrought iron frames, at the top bottom and sides, the whole being strengthened and kept in proper position by diagonal braces of the same material, lined with a thin casing of wood and fitted with a floor, seats, etc. for the convenience of persons making use of it, and passes up and down in a shaft or well, specially built for it, from the basement to the upper or sixth storey, a height of very nearly 100 feet. The greatest load which it is calculated to life is 10 cwts (1 cwt = 112 lbs.), or say seven persons, including the 'liftman' specially appointed to attend to this duty, and some baggage.
>
> The motive power supplied to the purpose of lifting, is supplied by a hydraulic ram, placed in an horizontal position under the basement floor, by means of which motion is given to a series of cog wheels, on to the shaft of the last of which are secured two iron drums two feet in diameter, round which

are wound two iron wire ropes, passing thence over pulleys in the top of the building and attached to a strong ring in the top of the cage which when moving in one direction raise, and in the other lower the hoist. To facilitate the ascent of the hoist and to assist in regulating it in its descent, and to take some of the strain off the wire ropes and the machinery generally, a heavy counterbalance weight is employed; this is attached to a long chain which, passing over pulleys fixed in a proper position in the top of the building, is attached to the top of the cage or hoist. The weight of the cage itself is about 7 cwts, and of its maximum load about 10 cwts more, while the weight of the counterbalance is about 26 cwts.

Self acting machinery is applied for regulating the height to which the hoist is to go at any time; and in addition to this ropes attached to the same machinery were passed through the cage by means of which the attendant could start or stop, the ascent or descent of the cage at pleasure, and this appears to have been the course most commonly pursued.

It appears that on the occasion to which this enquiry relates, the cage or hoist, containing its full complement of weight, and proceeding upwards towards the fifth floor, and had reached to halfway between the third and fourth floors, when its upward motion stopped, and it immediately began to descend and fell rapidly to the bottom of the shaft, followed at a very brief interval by the counterbalance weight with its chain and pulleys, by the winding pulleys over which the wire rope ran, and by more or less of the heavy iron girders on which the several pulleys were carried, which, crashing through the cage, caused the immediate death of one person and injuries more or less severe to others.

It is important to notice that when the cage attained its greatest altitude, and began to descend, the counterbalance weight must have been about 38 feet below the bottom of the cage.

The Course of the accident seems to have been that from a failure of the machinery (to be presently described) the cage fell rapidly; as it fell the counterbalance weight was run with great velocity to its full height near the top of the building, and then by either coming actually in contact with the pulley on which its chain worked, or by the shock caused by its sudden stoppage and rebound, broke the cross girder to which the pulley was fixed, and which carried also the ends of the two other girders on which were fixed the winding pulleys over which the wire ropes worked: part of this first girder was left firmly fixed in its proper position in the wall, the rest of it together with the two other girders and the pulleys above mentioned fell to the bottom. The progress of the fall of the counterbalance weight being most distinctly marked on the wall of the shaft and one of the floor landings.

From a minute examination of the whole of the machinery it would appear that the immediate cause of the accident must have been the breaking of the shaft, of the winding drums at the bottom; which destroyed the connection between them and the resisting pressure of the water on the ram. The cage being thus left unsupported ran rapidly to the bottom; its fall however partially retarded by the action of the counterbalance weight and chain and it is possible that there would have been no very serious results had it not been for the breaking of the girder at the top of the building and the consequent fall of the heavy materials already referred to.

An inspection of the broken part of the winding shaft shows that it had been partially broken, probably for some time before the accident; and that it at last failed by being actually twisted in two. The general dimensions and proportions of it are good and fully sufficient for the purposes for which it was designed.

> The fractured parts of the girder at the top of the building show that it was a perfectly good and sound casting without flaw or imperfection, and its dimensions were fully sufficient to withstand the strains which might have been expected to come upon it.
>
> William Mills
> Civil Engineer

Attached to this incredibly detailed report was a patent describing a new "improved patent safety hoist." The jury, armed with this information, then made their well informed verdict of accidental death but amended it with the following:

> At the same time the Jury, deploring the loss of Human Life occasioned by the accident, desires to express to the Directors and Company of the Grosvenor Hotel, their strong opinion of the necessity (Human Life so continually depending on it) that the works and machinery of the descending Room should be of the best materials and construction the Girders Wrot Iron, the Counter Weight to be secured in a Box, to hold it in its proper place, and that any alteration detrimental to its original mechanical or Engineering construction be corrected.

The coroner's jury had indeed come of age in many respects, and fought to control the associated hazards of a century undergoing exponential developments. Dr. Farr, a leader in the study of vital statistics in the nineteenth century, recognized the role coroners' inquests could play in providing information regarding the growing problem of occupational deaths. He commented in 1856 after reading the coroner's returns.[247]

> The progress of science has created new forces, often fatal, and has produced new substances, of which our forefathers had no knowledge. Machinery is organized on a large scale, so that the lives of numbers of men are liable to be destroyed, not by malacious intent, but by the negligence of other men who have their lives in charge.

The coroner's inquest was the only mediating factor documenting and attempting to control occupational deaths until the latter half of the nineteenth century when legislation would finally protect the British worker and delineate standards of safety.[248]

Despite these deaths due to large unprotected machines, most people died from simple injuries. Fractures were commonly a cause of death, if not from direct contamination of the wound and spreading infection, then from bedsores and subsequent respiratory infection while lying in bed waiting for a femur or hip to heal. A laborer fell, "fractured his thigh. . . formed bedsores which suppurated and died from Exhaustion."[249] Another woman fell while drunk, "fractured her thigh, got a few bedsores and was well for a few days but died suddenly. . . rapidly going downhill."[250] There is no mention in the inquests of any limb ever having been put in a cast. People frequently died from minor wounds too, if not from tetanus,[251] then from erysipelas. One man, a poulterer, had a superficial scalp wound [252] after being spurred by a cock and was bled by a surgeon as treatment. Another woman fell and cut her chin. She subsequently died of erysipelas.[253] If one was unlucky enough to get a finger or a limb mangled in machinery, gangrene inevitably

set in and amputation was necessary. In yet another lift accident, the lift man working the brake caught his hand in the chain of the hoist. The "2nd finger of his right hand was crushed but he refused amputation." He died from gangrene and subsequent "pyaemia."[254] Judging from the thirty accidental deaths resulting from reinfection and gangrene after amputation, it is difficult to determine whether the lift man made the wrong choice. In the eighteenth and nineteenth centuries, antibiotics were of course unknown, as were concepts of sterile procedure. As was mentioned with burn cases, mortality remained high even though more people were going to the hospital and reaching medical attention. Among the accidents, only one went to the hospital in the 1760 period. Yet in the later periods, 19, 47, and 55 per year respectively were taken to the hospital before death. Of these 376 accident victims to reach the hospital, 63% were men, 15% were women, and 22% were children under the age of ten. Over three quarters of the children and 40% of the women were taken to the hospital after a severe burn. These figures merely reflect the fact that men had more accidents in the first place. However, there was perhaps also a prejudice in the nineteenth century that children should be cared for at home,[255] and an aversion for a woman to enter an institution largely male. The obvious exceptions in both instances were in cases of burns and these made up a large percentage of the women and children who did go to the hospital.

HOSPITAL DEATHS*

	W	G	C	M	K	Disp	Total	#/yr
1761-5	1	--	--	--	--	--	1	--
1800-3	14	31	30	2	--	--	77	19
1835-8	60	125	--	--	--	4	189	47
1865-6	19	71	11	--	5	3	109	55

*The hospitals are: W = Westminster
G = St. George
C = Charing Cross
M = Hospital of St. Martin-in-the-Field
K = King's College
Disp = various local dispensaries

The century, reflected in these inquests, thus experienced a large increased incidence of accidental deaths, above the population growth. Accidents from falls increased more than proportionately, as did accidents from traffic and fire. Accidents due to drowning stayed largely the same, slightly decreasing, through the century, and inquests on suffocation of infants became more frequent. The coroners' juries in Westminster attempted to deal with the new era of occupational deaths and in many cases questioned the circumstances in tremendous detail. The coroners' energies, so apparent throughout the inquests, along with the close general agreement with national statistics, suggests that the coroner held an inquest on nearly every accidental death. This alone is quite an amazing achievement. Lastly, the inquests emphasize how extremely vulnerable human life was at this time. An accidental death might result nearly as easily from trivial as from massive injuries.

CONCLUSION

The coroner's system evolved from a multitude of pecuniary activities and purposes to approach the present day coroner of forensic medicine. The coroner has a colorful history and recorded detailed information not available from other channels. However, these numerous details were never systematized to be easily accessible, and despite the Registrar General's high hopes to make use of "the coroners' information [which] furnish many valuable facts,"[256] the information compiled by the coroners all over the country for centuries was largely lost. Brend bemoaned that the

> value of the [coroner's] statistics is diminished by absence of coordination. . . Hence we have the anomaly that while a full inquiry is conducted into deaths from violence and unnatural causes, practically no subsequent use is made of the information for public health purposes.[257]

The Westminster inquests comprise the most complete known collection of inquests of the eighteenth and nineteenth centuries. As indicated by Brend and others, this is a unique source of information, and this thesis is the first attempt at organizing and analyzing the Westminster inquests. These data when organized, especially in cases of felonious and accidental deaths, provide a means for evaluating the effects of social and occupational change in a pivotal century.

FOOTNOTES

1. F. J. Waldo, "The Ancient Office of Coroner," Trans. Medico-Legal Soc., London, 1911, v. 8, p. 102.

2. Waldo, p. 104.

3. Waldo, p. 103.

4. R. Henslowe Wellington, The King's Coroner, London, 1905, v. 1, p. 2.

5. Sir Travers Twiss, ed., Bracton's De Legibus Angliae, London, 1878, v. 2, p. 281.

6. F. M. Nichols, ed., Britton, Oxford, 1865.

7. Waldo, p. 107.

8. Charles Gross, "The Early History of the Office of Coroner," Political Science Quarterly, 1892, v. 7, no. 4, pp. 656-672.

9. Gross, p. 657.

10. R. F. Hunnisett, Medieval Coroner, Cambridge, 1961, p. 1. Also, R. F. Hunnisett, "The Origins of the Office of Coroner," Trans. R. Hist. Soc., 5th series, 8:85-104.

11. Wellington, p. 3.

12. A. Keith Mant, "The Evolution of the Coroner's System," Forensic Sci. Gaz., 1971, 2:106.

13. The Articles of Eyre refer to the office "custus placitorum corone," or guardian of the pleas of the Crown. Waldo, p. 101.

14. Waldo, p. 132.

15. Mant, p. 1.

16. Hunnisett, Medieval Coroner, p. 2.

17. Enumeration Abstract of the 1811 Census, London, 1813, p. xi.

18. Mant, p. 2.

19. Hunnisett, Medieval Coroner, p. 4.

20. Mant, p. 2.

21. Ibid., p. 3.

22. Ibid., p. 3.

23. Waldo, p. 121.

24. Ibid., p. 122.

25. Wellington, p. 8.

26. Hunnisett, Medieval Coroner, p. 7.

27. Wellington, p. 11.

28. John Wilkinson, The Office and Authorities of Coroners and Sherifes, London, 1651, p. 48. Wilkinson bases his treatise on Bracton.

29. Mant, p. 4.

30. Hunnisett, Medieval Coroner, p. 5.

31. Mant, p. 2.

32. Hunnisett, Medieval Coroner, p. 10.

33. Ibid., p. 18.

34. Ibid., p. 13.

35. Ibid., p. 20.

36. Ibid., p. 34.

37. Waldo, p. 112. Origin also reviewed in "A Note upon Deodands," by William Westcott, in Trans. Med. Leg. Soc., London, 1910, 10:91097.

38. Wilkinson, p. 23.

39. Forbes mentions that in one case a horse kicked the victim in the head and the horseshoe was declared the deodand, valued at 1s. Thomas R. Forbes, "Coroners' Inquests in the County of Middlesex, England, 1819-42," J. Hist. Med., 1977, 32:382.

40. Hunnisett, Medieval Coroner, p. 33.
41. Ibid., p. 22.
42. Gross, p. 671.
43. Hunnisett, Medieval Coroner, p. 22.
44. Nichols, Britton, p. 10.
45. Gross, p. 669.
46. Hunnisett, Medieval Coroner, p. 15.
47. Gross, p. 671.
48. Hunnisett, Medieval Coroner, p. 138.
49. Statute 3, Edw I, ch. 10 (1275).
50. Hunnisett, Medieval Coroner, p. 136.
51. Wellington, p. 5.
52. Hunnisett, Medieval Coroner, p. 164.
53. Ibid., p. 177.
54. Ibid., p. 183.
55. Gross, p. 664.
56. Hunnisett, Medieval Coroner, p. 196.
57. Ibid., p. 194.
58. Ibid., p. 173.
59. Statute I, Edw III, ch. 8 (1340).
60. Hunnisett, Medieval Coroner, p. 176.
61. Ibid., p. 189.
62. Wilkinson, p. 2.
63. Mant, p. 2.
64. Mant, p. 4.

65. R. F. Hunnisett, Calendar of Nottinghamshire Coroners' Inquests 1485-1558, Nottingham, 1969, p. ii.

66. Mant, p. 4.

67. Statute 3, Henry VII, ch. 2 (1487).

68. Hunnisett, Calendar, p. xviii.

69. Statute 1, Henry VIII, ch. 7 (1509).

70. Hunnisett, Calendar, p. xviii.

71. Statute 25, Geo II, Ch. 29 (1751).

72. Mant, p. 5.

73. These rolls are nearly complete for 1270-1276 and were studied by Hunnisett in his "Bedfordshire Coroners' Rolls," Publ. Bedforshire Histor. Record Soc., 1961, 41:1-165.

74. Hunnisett, Calendar, p. xvii.

75. With more regular rolls, coroners records were preserved in Shropshire and formed the basis for Hair's study, "Accidental Death and Suicide in Shropshire, 1780-1809," Trans. Shropshire Archaeol. Soc., 1969, 59:63-75.

76. Hunnisett, Calendar.

77. F. A. Bailey, "Coroners' Inquests Held in the Manor of Prescot, 1746-89," Trans. Hist. Soc. Lancashire and Cheshire, 1934, 86:21-39.

78. Thomas R. Forbes, Crowner's Quest, Philadelphia, 1978.

79. The parish lines defining Westminster did not change according to maps of the area in 1766, 1829, 1850, and 1866. Cruchley's map of 1829 was kindly provided by Dr. Thomas Forbes and the other maps are part of the map collection at the District Library for the City of Westminster, Buckingham Palace Road, London.

80. This information was supplied by Mr. N. H. MacMichael, Keeper of the Muniments, and Mr. Howard M. Nixon, Librarian, at the Muniment Room and Library, Westminster Abbey, London.

81. Personal communication from Mr. N. H. MacMichael.

82. R. Henslowe Wellington, author of The Kings Coroner, also held this title in the beginning of the twentieth century.

83. Hunnisett, Medieval Coroner, p. 164.

84. Personal communication from Mr. N. H. MacMichael. The information is derived from J. L. Chester's edition of the Westminster Abbey Registers.

85. Hunnisett, Calendar, p. xvi.

86. Information owed MacMichael as noted above.

87. Hunnisett, Medieval Coroner, p. 177.

88. Mant, p. 5.

89. Personal communication with Miss J. Coburn, Head Archivist, Greater London Record Office, Middlesex Records, 1 Queen Anne's Gate Buildings, Dartmouth Street, London.

90. Statute 1, Edw III, ch. 8 (1340).

91. Statute 25, Geo II, ch. 29 (1751).

92. Forbes, "Middlesex 1819-42," pp. 376-377.

93. John Burnett in his History of the Cost of Living (1969) states that an annual budget of five hundred pounds in 1834 would provide for a family of five with two maids, pp. 235-238.

Food	150 pounds
Rent (10 room house)	35 pounds
Two Maids	30 pounds
Clothing Expenses	100 pounds
Education of children	10 pounds
Office expenses (lunch, etc.)	25 pounds
Coal	12 pounds
Taxes	25 pounds
Travel or Savings	100 pounds

94. Wilkinson, p. 30.

95. Hunnisett, Medieval Coroner, p. 5.

96. October 21, 1763, in Westminster inquests.

97. Hunnisett, Medieval Coroner, p. 33.

98. Statute 21, James, I, ch. 27 (1623).

99. For a detailed discussion about infanticide and the inquest in the nineteenth century see Yale thesis by Gary Greenwald, 1980.

100. January 24, 1837, in Westminster inquests.

101. However, Forbes states that several suicides formally declared "felo de se" were buried in the churchyard and recorded in the parish register of burials. See "Mortality Books for 1774-93 and 1833-5 from the Parish of St. Giles, Cripplegate," Bull. N.Y. Acad. Med., 1971, 47:15-35.

102. May 1, 1762 in Westminster inquests.

103. T. R. Forbes, Crowner's Quest, p. 38.

104. Hunnisett, Calendar, p. x.

105. March 8, 1865, in Westminster inquests.

106. May 3, 1865, in Westminster inquests.

107. December 15, 1801, in Westminster inquests.

108. Hunnisett, Medieval Coroner, p. 17.

109. July 16, 1866, in Westminster inquests.

110. September 25, 1865, in Westminster inquests.

111. Enumeration Abstract of the Census, 1801 and 1831, London.

112. June 14, 1836, in Westminster inquests.

113. June 4, 1800, in Westminster inquests.

114. April 14, 1801, in Westminster inquests.

115. March 3, 1865, and March 9, 1865, in Westminster inquests.

116. April 14, 1801, in Westminster inquests.

117. January 1, 1800, in Westminster inquests.

118. The "pub" may have afforded the only room large enough to accommodate a jury in the eighteenth century.

119. October 20, 1801, in Westminster inquests.

120. On February 18, 1835, disinterrment was ordered and an autopsy performed.

121. January 5, 1865, in Westminster inquests.

122. Hunnisett, Medieval Coroner, p. 20.

123. April 23, 1835, in Westminster inquests.

124. September 5, 1865, in Westminster inquests.

125. February 8, 1764, in Westminster inquests.

126. January 1, 1765, in Westminster inquests.

127. July 7, 1865, in Westminster inquests.

128. April 17, 1835, in Westminster inquests.

129. March 16, 1838, in Westminster inquests.

130. The collection of "Surgeon's Accounts" were available in 1827 and for 1837-1844.

131. The fifty pound deodand was assessed on January 15, 1837.

132. January 26, 1765, in Westminster inquests.

133. October 25, 1836, in Westminster inquests.

134. August 13, 1835, in Westminster inquests.

135. March 19, 1836, in Westminster inquests. Thomas Pettigrew was a surgeon of "distinction":

> "He was descended from the priest Clerk Pettigrew, who figures in Walter Scott's novel Rob Roy, and his father was a navel surgeon in the 'Victory' long before Nelson's time. He began studying anatomy when he was only 12 and gave his first lecture at the age of 17 to the City Philosophical Society on Insanity. He had made a close study of the diseases of children and had carried out experiments (in his own home and at his own expense) on the employment of galvanism in cases of suspended animation. The Royal Humane Society awarded him their medal for the restoration to life of a case of apparent death. He had vaccinated Queen Victoria when she was an infant, for he was surgeon both to her

father the Duke of Kent and to the Duke of Sussex."
R. J. Minney, The Two Pillars of Charing Cross, London, 1967, pp. 66-67.

Pettigrew was Surgeon for the "West London Infirmary," when it was established by Dr. Golding to provide medical aid to the poor, and which subsequently became Charing Cross Hospital. He also taught at the Medical School established in 1822, providing lectures on anatomy, physiology, pathology, and the principles and practice of surgery. He was not paid by the Hospital, and received only a small portion of the fees paid by the students. Private practice supplied his finances. Benjamin Golding, Charing Cross Hospital, London, 1867, p. 28.

136. Farr states in the First Annual Report of the Registrar General (1839), p. 72,
"consumption and mesenteric disease and hydrocephelus are in reality a modification of scrofula. . . exceedingly fatal in ill-ventilated, dirty neighborhoods, where the inhabitants are poor, and the mothers are ill-fed."

137. January 21, 1836, in Westminster inquests. For more information concerning the workhouse see Norman Longmates' The Workhouse, London, 1974.

138. May 14, 1836, in Westminster inquests.

139. May 14, 1836, in Westminster inquests.

140. January 21, 1836, in Westminster inquests.

141. Hunnisett, Calendar, p. xx.

142. Forbes, "Middlesex," p. 376.

143. January 1, 1835, in Westminster inquests.

144. I am indebted to MacMichael, cf. 84.

145. January 15, 1866, in Westminster inquests.

146. Surgeon's accounts from March 16, 1838, May 1, 1838, June 9, 1838, and September 6, 1838.

147. September 6, 1838, in Westminster inquests.

148. November 14, 1836, in Westminster inquests.

149. William Brend, Statistics of Deaths from Violence and Unnatural Causes, London, 1915, p. 19.

150. Registrar General, 6th Annual Report, London, 1842.

151. Walford lists data extracted from the Registrar General to indicate rates of violence for the Metropolis in the single year 1838. Cornelius Walford, "Number of Deaths from Accident, Negligence, Violence and Misadventure in the United Kingdom," J. Stat. Soc., 1881, 44:455.

152. Brend, Statistics, p. 16.

153. William Brend, "Bills of Mortality," Trans. Med-Legal Soc., 1907, 5:140.

154. Thomas R. Forbes, "Burial Records for the Parish of St. Anne Soho, in 1814-28," Yale J. Biol. Med., 1974, 47:93-100.

_____, "By What Disease of Casualty: The Changing Face of Death in London," J. Hist. Med., 1976, 31:395-420.

_____, Chronicle from Aldgate, New Haven, 1971.

_____, "Mortality Books for 1774-93 and 1833-5 from the Parish of St. Giles, Cripplegate, London," Bull. N.Y. Acad. Med., 1971, 47:1524-1536.

_____, "Sextons' Day Books for 1685-7 and 1694-1703 from the Parish of St. Martin-in-the-Fields, London," Yale J. Biol. Med., 1973, 46:142-150.

155. Brend, "Bills," p. 143.

156. Walford, p. 445.

157. John Graunt, Bills of Mortality, Oxford, 1665, 4th edition, p. 19.

158. The limitations and inaccuracies have been frequently addressed beginning with Graunt. For additional information see Forbes' "The Searchers," Bull. N.Y. Acad. Med., 1974, 50:1031-8.

159. Cf. 157.

160. Glass describes these four as those responsible for major attempts at demographic reconstruction. He excludes Marshall as he largely adopts the calculations of Brownlee. D. V. Glass, "Population in England and Wales 1700 to 1850," in Population in History, London, 1965, p. 221.

161. Enumeration Abstract of the 1811 Census, London, 1812, p. ix.

162. J. T. Krause, "Changes in English Fertility and Mortality, 1781-1850," in Glass' Population in History, pp. 52-70.

163. Through the latter three periods, Westminster had sequentially 17%, 16%, and 15% of the population of London according to the census returns. Based on this approximate constancy, Westminster was estimated to be 17% of London's population in 1760.

	Westminster	%	London
1760	(120,000)	17	*700,000
1801	151,587	17	900,000
1821	182,088	16	1,144,531
1831	201,419	15	1,302,739
1841	221,549	--	--
1851	244,302	10	2,362,236
1861	254,623	9	2,803,989

Westminster became a smaller proportion of London as London continued to grow through the nineteenth century.

*This is an estimate by Farr. This is probably very accurate, given that population estimates by either Farr, Brownlee or Griffith, arrived at by different methods of calculation, agree within an error of three per cent. Glass comments that estimates of population a half century apart are likely to be very accurate, whereas estimates of variations year to year are much more difficult to ascertain (p. 238 of Population in History).

The population for Westminster in this study will be 120,000 for 1760-5, 150,000 for 1800-3, 220,000 for 1835-8, and 250,000 for 1865-6.

164. Farr in Registrar General, First Annual Report, 1838, p. 71.

165. Graunt, p. 22.

166. Forbes, "St. Anne Soho," p. 95.

167. Registrar General, 28th Annual Report, 1865.

168. Graunt, p. 31.

169. Farr in Registrar General, First Annual Report, 1838, p. 89.

170. Forbes, "Changing Face of Death," p. 407.

171. Bills compiled by both Thomas Short, Comparative History of the Increase and Decrease of Mankind, London, 1767, p. 23, and by William Black, Diseases and Mortality of the Human Species, London, 1789, p. 102.

172. Registrar General, 28th Annual Report, 1865.

173. Registrar General, First Annual Report, 1838, p. 180.

174. Forbes, "Middlesex," p. 386.

175. Editorial, "Death by visitation of God," Lancet, 1841, 1:452.

176. The Whitby coroner rejoined, "he was happy to say he had not yet outlived his belief in God, and he hoped it would be long before an English jury could be found that had done so," cf. 26.

177. Umfreville, p. 26.

178. J. R. McCulloch, A Descriptive and Statistical Account of the British Empire, London, 1854, v. 2, p. 566.

179. McCulloch, p. 566.

180. Forbes, "Middlesex," p. 387.

181. Registrar General, 28th Annual Report, 1865, p. 162 and 29th Annual Report, 1866, p. 162.

182. Hair, "Deaths from Violence in Britain: A Tentative Secular Survey," Pop. Studies, 1971, 25:11.

183. Hair, "Violence," p. 12.

184. For a history of the London police see Donald Rumbelow, I Spy Blue, London, 1971.

185. Walford, pp. 455-457.

186. Registrar General, First Annual Report, 1838, p. 77.

187. Hunnisett, p. 11.

188. Statute 1, Henry VIII, ch. 7.

189. December 19, 1838, in Westminster inquests.

190. January 16, 1837, in Westminster inquests.

191. January 16, 1837, in Westminster inquests.

192. July 30, 1838, in Westminster inquests.

193. Wellington, p. 18.

194. Statutes IX, X, Vict. ch. 62.

195. In general, all comparisons are made with values per million population per annum.

196. Registrar General, 1838, p. 455, 1856, p. 457, 1865, p. 463.

197. January 5, 1835, in Westminster inquests.

198. January 5, 1835, in Westminster inquests.

199. January 30, 1865, in Westminster inquests.

200. Hair, "Violence," p. 7.

201. Ibid.

202. Ibid., p. 9.

203. Ibid., p. 8.

204. January 13, 1865, in Westminster inquests.

205. July 20, 1837, in Westminster inquests.

206. Hair, "Violence," p. 12.

207. March 26, 1866, in Westminster inquests.

208. Hair, "Violence," p. 12.

209. Ibid., p. 13.

210. The Gentleman's Magazine, 1806, p. 1204.

211. The Royal Humane Society operated through the century and actively trying to control accidental drownings. Reference is made in the inquests to signs put up by the society "when the ice is dangerous (to skaters) and frequently drowned victims were brought to the Humane Society Receiving House to attempt various "stimulating remedies" for revival (cf. 62 in Westminster Inquests). Charles Dickens in his Dictionary of London, London, 1880, p. 137, defines the Royal Humane Society as "Receiving houses and places appointed for receiving persons apparently drowned."

212. Forbes, "Middlesex," p. 392.

213. Registrar General, Annual Report, 1850.

214. Hair, "Violence," p. 12.

215. February 12, 1764, in Westminster inquests.

216. September 14, 1837, in Westminster inquests.

217. October 8, 1836, in Westminster inquests.

218. Brend, "Statistics," p. 58.

219. May 20, 1836, in Westminster inquests.

220. Forbes, Crowners' Quest, p. 24.

221. Walford, p. 464.

222. This theory is maintained by Forbes and Hair.

223. Statute 21, James I, ch. 27.

224. Brend, "Statistics," p. 55.

225. Ibid., p. 52.

226. Hair, "Mortality from Violence in British Coal-Mines, 1800-50," Econ. Hist. Rev., 1968, 21:545-61.

227. Hair, "Violence," p. 24.

228. F. S. F. Schilling, Occupational Health Practice, London, 1973, p. 9.

229. July 27, 1865, in Westminster inquests.

230. Schilling, p. 11.

231. Walford, p. 454.

232. July 31, 1865, in Westminster inquests.

233. March 7, 1866, in Westminster inquests.

234. January 4, 1836, in Westminster inquests.

235. August 31, 1866, in Westminster inquests.

236. May 29, 1865, in Westminster inquests.

237. October 8, 1838, in Westminster inquests.

238. This is the same railroad against which was charged the 2000 pound deodand cited earlier, cf. 193.

239. August 8, 1835, in Westminster inquests.

240. September 29, 1837, in Westminster inquests.

241. April 28, 1865, in Westminster inquests.

242. May 19, 1838, in Westminster inquests.

243. March 25, 1865, in Westminster inquests.

244. May 27, 1865, in Westminster inquests.

245. May 19, 1835, in Westminster inquests.

246. June 26, 1865, in Westminster inquests.

247. Farr in his letter to the Registrar General, Annual Report, 1856.

248. Schilling, p. 11.

249. May 18, 1865, in Westminster inquests.

250. January 13, 1865, in Westminster inquests.

251. January 4, 1836, in Westminster inquests.

252. May 31, 1865, in Westminster inquests.

253. May 8, 1866, in Westminster inquests.

254. December 5, 1866, in Westminster inquests. In this half-century before sterile procedure in surgery, data exist that of 13,000 amputations performed by surgeons, 10,000 proved to be fatal. John Langdon Davies, Westminster Hospital, 1719-1948.

255. Forbes, "Changing Face of Death," p. 410.

256. Registrar General, 6th Annual Report, 1842.

257. Brend, "Statistics," p. 13.

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